

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08240

CERTIFICATE OF DEATH

08229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2732 W. Fairmount Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last ALEXANDER				4. DATE OF DEATH Month August Day 11 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1900	
9. AGE (In years last birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Tampa, Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Alexander		14. MOTHER'S MAIDEN NAME Fannie Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 134-03-9197		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM & INFARCTION, THROMBOSIS OF LEFT & RIGHT AURICLES DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 8, 1957 , to August 11, 1957 , that he died on August 11, 1957 , and that death occurred at 6:10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Chien Wei Lan		M. D. VAH, FORT HOWARD, MD.					
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.		8/12/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/57		22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice				ADDRESS 661 W. Barre		24a. REC'D BY REGISTRAR 8/10/57	
				24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

BUREAU V. S.

JUG 20 1957

RECEIVED

08241

CERTIFICATE OF DEATH

08230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-TOWSON</u> c. LENGTH OF STAY IN 1b <u>5WKS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT-1-BOX 182-BLENHEIM RD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-TOWSON XI</u> d. STREET ADDRESS <u>BOX 182-BLENHEIM RD</u>			
3. NAME OF DECEASED (Type or print) <u>KATIE</u> First <u>VIOLA</u> Middle <u>BAILEY</u> Last				4. DATE OF DEATH Month <u>AUG.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHT.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 14, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>212-14-9281</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN HORSEMAN</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-144281</u>		17. INFORMANT <u>ETHEL FLEMING</u> Address <u>FOREST HILL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 7th</u> 19 <u>57</u> , to <u>Aug 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>57</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. X. Quinn</u> M.D.				ADDRESS (Street, city or town, state) <u>1927 York Rd., TIMONIUM Md</u>			
DATE SIGNED <u>8/28/57</u>				PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HEBRON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HEBRON-WIC. CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook, Inc</u>				ADDRESS <u>1217 ST. PAUL ST.</u>		24. REC'D BY REGISTRAR <u>AUG 30 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Michael Gray</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

AUG 30 1957

RECEIVED

DEPARTMENT OF HEALTH - BALTIMORE DIVISION OF VITAL RECORDS 100 NORTH EIGHTH STREET BALTIMORE, MARYLAND 21201		DATE OF DEATH 1957	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08242

Item 4 Film 220 9-6-57 et

CERTIFICATE OF DEATH

08231

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights, Maryland 16x0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 7108 Belwood St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Helen Middle Bernadette Last Barbeau				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY Massachusetts			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Cannon			14. MOTHER'S MAIDEN NAME Susan Miller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 6 , 19 57 , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ellis S. Mary M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-57		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET Cem.		22d. LOCATION (City, town, or county) (State) WASH D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Havelow				ADDRESS 3831 - S. Annapolis		24a. REC'D BY REGISTRAR AUG 29 '57	
				24b. REGISTRAR'S SIGNATURE Alfred			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		JULY 1957	
COUNTY		BALTIMORE	
MARRIAGE		SINGLE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
RELIGION		METHODIST	
RACE		WHITE	
SEX		MALE	
AGE		35	
DATE OF BIRTH		JULY 1922	
PLACE OF BIRTH		BALTIMORE, MD	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. SMITH	
SIGNATURE OF REGISTRAR		J. H. SMITH	
SIGNATURE OF WITNESSES		J. H. SMITH	
SIGNATURE OF DECEASED		J. H. SMITH	
SIGNATURE OF NEXT OF KIN		J. H. SMITH	
SIGNATURE OF BURIAL OFFICIAL		J. H. SMITH	
SIGNATURE OF INTERVIEWER		J. H. SMITH	
SIGNATURE OF CLERK		J. H. SMITH	
SIGNATURE OF ASSISTANT CLERK		J. H. SMITH	
SIGNATURE OF RECEPTIONIST		J. H. SMITH	
SIGNATURE OF TELEPHONE OPERATOR		J. H. SMITH	
SIGNATURE OF MAIL ROOM CLERK		J. H. SMITH	
SIGNATURE OF RECORDS CLERK		J. H. SMITH	
SIGNATURE OF CHIEF CLERK		J. H. SMITH	
SIGNATURE OF DEPARTMENT CHIEF		J. H. SMITH	

BUREAU V. S.

AUG 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08243

CERTIFICATE OF DEATH

0823238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>4 dys</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armaeost Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Kingsville</u> d. STREET ADDRESS <u>Hillside & Cross Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Christine</u> First <u>Bathelmes</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>22</u> Day <u>57</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George Kammer</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Fehr</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-2995</u>		17. INFORMANT <u>Frdek W Barthelmes 122 Elinor Ave Balto 6 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis with cardiac decompensation</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>360x</u> (b) <u>arteriosclerotic cardiovascular disease - Generalized</u> DUE TO <u>arteriosclerotic atherosclerosis with hyperplasia</u> (c) <u>Diabetes (with overlapping Retinal Hemorrhage) Carcinoma Pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 dys</u> <u>3 yrs. +</u> <u>Diabetes 3 yrs +</u> <u>Pancreas 3 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrenous ulceration Dorsum Rt. Foot, Beginning gangrene Rt. leg - 1st</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 11, 1954</u> , to <u>August 22, 1957</u> , that I last saw the deceased alive on <u>August 21</u> , 1957, and that death occurred at <u>1:15 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bal Air Rd - Kingsville</u> DATE SIGNED <u>Isabel H. McClinton M.D.</u>							
ACTUAL SIGNATURE <u>Isabel H. McClinton M.D.</u> M.D. <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>August 26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u>				24a. REC'D BY REGISTRAR <u>AUG 28 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>							

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John H. Williams</i></p>		<p>AGE <i>40</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Aug 29 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Artery Disease</i></p>	
<p>DATE OF BIRTH <i>Aug 10 1917</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>DATE OF DEATH <i>Aug 29 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Artery Disease</i></p>	
<p>DATE OF BIRTH <i>Aug 10 1917</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>DATE OF DEATH <i>Aug 29 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Artery Disease</i></p>	

BUREAU V. 1

AUG 29 1957

RECEIVED

08244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>				c. LENGTH OF STAY IN 1b <u>148 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>C.</u> Last <u>BARTLETT</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/18/94</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Company</u>		11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bartlett</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Hoover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>274-05-8406</u>		17. INFORMANT <u>Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCT MULTIPLE</u> DUE TO <u>AURICULAR THROMBOSIS, BILATERAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to: AORTIC STENOSIS AND INSUFFICIENCY</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from <u>April 5, 1957</u> to <u>August 31, 1957</u> and that death occurred at <u>2:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>9-1-57</u> ACTUAL SIGNATURE <u>Chien Wei Lan</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> 9-1-57 PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> 9-1-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER & SONS, INC., Aves., Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
AGE		SEX	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
AGE		SEX	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
AGE		SEX	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

RECEIVED

SEP 4 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08245

Items 5.6 Film 220 9-6-57 et

CERTIFICATE OF DEATH

08234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Towson 12</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>405 Hopkins Road</u>		d. STREET ADDRESS <u>1405 Hopkins Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>Battaglia</u> Last <u>Battaglia</u>		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cefala Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>John Battaglia</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John F. Battaglia</u>		Address <u>405 Hopkins Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardio vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 15, 1954</u> to <u>August 30, 1957</u> , that I last saw the deceased alive on <u>August 30, 1957</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8/30/57</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Philip D. Flynn</u>		M.D. <u>11 East Chase Street, Baltimore 2, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip D. Flynn, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto. 29 - Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Garano Inc. 712-14 E North Ave</u>		ADDRESS <u>Aug. 31 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>R.W. Mabel Gray</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>1892-10-15</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1915-05-10</i>	
9. NAME OF SPOUSE <i>John A. Smith</i>		10. DATE OF DEATH <i>1957-08-15</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
15. SIGNATURE OF DECEASED <i>John A. Smith</i>		16. SIGNATURE OF WITNESS <i>John A. Smith</i>	
17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF WITNESS <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF WITNESS <i>John A. Smith</i>	
21. SIGNATURE OF DECEASED <i>John A. Smith</i>		22. SIGNATURE OF WITNESS <i>John A. Smith</i>	
23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF WITNESS <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF WITNESS <i>John A. Smith</i>	
27. SIGNATURE OF DECEASED <i>John A. Smith</i>		28. SIGNATURE OF WITNESS <i>John A. Smith</i>	
29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF WITNESS <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF WITNESS <i>John A. Smith</i>	
33. SIGNATURE OF DECEASED <i>John A. Smith</i>		34. SIGNATURE OF WITNESS <i>John A. Smith</i>	
35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF WITNESS <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF WITNESS <i>John A. Smith</i>	
39. SIGNATURE OF DECEASED <i>John A. Smith</i>		40. SIGNATURE OF WITNESS <i>John A. Smith</i>	
41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF WITNESS <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF WITNESS <i>John A. Smith</i>	
45. SIGNATURE OF DECEASED <i>John A. Smith</i>		46. SIGNATURE OF WITNESS <i>John A. Smith</i>	
47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF WITNESS <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF WITNESS <i>John A. Smith</i>	
51. SIGNATURE OF DECEASED <i>John A. Smith</i>		52. SIGNATURE OF WITNESS <i>John A. Smith</i>	
53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF WITNESS <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF WITNESS <i>John A. Smith</i>	
57. SIGNATURE OF DECEASED <i>John A. Smith</i>		58. SIGNATURE OF WITNESS <i>John A. Smith</i>	
59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF WITNESS <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF WITNESS <i>John A. Smith</i>	
63. SIGNATURE OF DECEASED <i>John A. Smith</i>		64. SIGNATURE OF WITNESS <i>John A. Smith</i>	
65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF WITNESS <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF WITNESS <i>John A. Smith</i>	
69. SIGNATURE OF DECEASED <i>John A. Smith</i>		70. SIGNATURE OF WITNESS <i>John A. Smith</i>	
71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF WITNESS <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF WITNESS <i>John A. Smith</i>	
75. SIGNATURE OF DECEASED <i>John A. Smith</i>		76. SIGNATURE OF WITNESS <i>John A. Smith</i>	
77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF WITNESS <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF WITNESS <i>John A. Smith</i>	
81. SIGNATURE OF DECEASED <i>John A. Smith</i>		82. SIGNATURE OF WITNESS <i>John A. Smith</i>	
83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF WITNESS <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF WITNESS <i>John A. Smith</i>	
87. SIGNATURE OF DECEASED <i>John A. Smith</i>		88. SIGNATURE OF WITNESS <i>John A. Smith</i>	
89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF WITNESS <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF WITNESS <i>John A. Smith</i>	
93. SIGNATURE OF DECEASED <i>John A. Smith</i>		94. SIGNATURE OF WITNESS <i>John A. Smith</i>	
95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF WITNESS <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF WITNESS <i>John A. Smith</i>	
99. SIGNATURE OF DECEASED <i>John A. Smith</i>		100. SIGNATURE OF WITNESS <i>John A. Smith</i>	

BUREAU V. B.

SEP 3 1957

RECEIVED

08246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 3529 Old Frederick Rd.	
3. NAME OF DECEASED (Type or print) First Bertha Middle C. Last Beard		4. DATE OF DEATH Month August Day 24 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Taylor		14. MOTHER'S MAIDEN NAME Fannie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Fannie Browning		Address 3529 Old Fred. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 2, 1957 , to August 24, 1957 , that I last saw the deceased alive on August 16, 1957 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Arthur Rosenberg MD		ADDRESS (Street, city or town, state) 2436 WASHINGTON BLVD DATE SIGNED 8/26/57	
PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG MD		BALTIMORE 30 MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-27-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.		24a. REC'D BY REGISTRAR DATE AUG 28 57	
		24b. REGISTRAR'S SIGNATURE Qu...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 28 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08247

CERTIFICATE OF DEATH

08236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO LUTHERVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1425 FRONT AVE.	
3. NAME OF DECEASED (Type or print) HOWARD M. BENSON		4. DATE OF DEATH 8 / 10 / 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/83
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MOVING + STORAGE	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS M. BENSON		14. MOTHER'S MAIDEN NAME SARAH THORNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Chas. F. Benson		Address 1425 FRONT AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 177X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1957, to 10th Aug. , 1957, that I last saw the deceased alive on July 20, 1957 , and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. K. Quinn		ADDRESS (Street, city or town, state) York Rd, Timonium	
PHYSICIAN'S NAME (Type) M. K. QUINN		DATE SIGNED 8/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/13/57	
22c. NAME OF CEMETERY OR CREMATORY MORELAND PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE CO. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan		ADDRESS 3818 ROLING AVE.	
24a. REC'D BY REGISTRAR AUG 12 '57		24b. REGISTRAR'S SIGNATURE Rebecca	

CERTIFICATE OF DEATH

CLASS OF DEATH (a) Natural () (b) Accidental () (c) Suicide () (d) Homicide () (e) Undetermined ()		MARITAL STATUS (a) Single () (b) Married () (c) Widowed () (d) Divorced ()	
PLACE OF DEATH (a) Home () (b) Hospital () (c) Nursing Home () (d) Prison () (e) Other ()		PLACE OF BIRTH (a) Maryland () (b) Other State () (c) Foreign ()	
DATE OF DEATH (a) (b) (c)		TIME OF DEATH (a) (b) (c)	
SEX (a) Male () (b) Female ()		AGE (a) (b) (c)	
OCCUPATION (a) (b) (c)		CAUSE OF DEATH (a) (b) (c)	
MANNER OF DEATH (a) (b) (c)		MEDICAL HISTORY (a) (b) (c)	
SIGNATURE OF DECEASED (a) (b) (c)		SIGNATURE OF WITNESS (a) (b) (c)	
SIGNATURE OF PHYSICIAN (a) (b) (c)		SIGNATURE OF CORONER (a) (b) (c)	
SIGNATURE OF JUDGE (a) (b) (c)		SIGNATURE OF CLERK (a) (b) (c)	

RECEIVED
 AUG 12 1957
 BUREAU Y. &

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08248

CERTIFICATE OF DEATH

08237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 Montrose Ave.		d. STREET ADDRESS 217 Montrose Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENIE Middle CROLAIS Last BETTS		4. DATE OF DEATH Month Aug. Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henri Crolais		14. MOTHER'S MAIDEN NAME ? Hamon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Karl S. Betts		Address 217 Montrose Ave. Catonsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cerebrovascular disease 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1957 , to Aug 13, 1957 , that I last saw the deceased alive on Aug. 7, 1957 , and that death occurred at 9:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. 1118 St. Paul St.			
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR		Baltimore 2, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Stone		24a. REC'D BY REGISTRAR AUG 19 57	
ADDRESS Catonsville 28, Md.		24b. REGISTRAR'S SIGNATURE Overhach	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CLERK [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF NOTARY [Illegible]	

BUREAU V. S.

AUG 19 1957

RECEIVED

08249

CERTIFICATE OF DEATH

Reg. Dist. No.

08238

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7812 Overbrook Rd.		d. STREET ADDRESS 7812 Overbrook Rd.	
3. NAME OF DECEASED (Type or print) First LYLE Middle BLANCHARD Last BLANCHARD		4. DATE OF DEATH Month Aug. Day 26 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY Marine Surveyors	9. AGE (In years last birthday) 68 yrs.
11. BIRTHPLACE (State or foreign country) La.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herman -		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -yes		16. SOCIAL SECURITY NO. World War I	
17. INFORMANT Mrs. Helena M. Blanchard - 7812 Overbrook Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10, 1947 , to Aug. 26, 1957 , that I last saw the deceased alive on Aug. 26, 1957 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		DATE SIGNED 6805 York Rd	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		ADDRESS (Street, city or town, state) Baltimore 12, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/29/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24a. REC'D BY REGISTRAR DATE 30 1957	24b. REGISTRAR'S SIGNATURE Nobel Luepke

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 30 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottle copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08239

08250

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Reisterstown</u>		<u>5 yrs</u>		TOWN <u>Reisterstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>434 Main Street</u>				STREET ADDRESS (If rural give location) <u>434 Main Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertha</u> (Middle) <u>Elizabeth</u> (Last) <u>Bowersox</u>				(Month) <u>Aug</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>November 21 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin L Waltz</u>				14. MOTHER'S MAIDEN NAME <u>Julia Pennington Dingle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>176-26-0665</u>		17. INFORMANT & ADDRESS <u>Mrs Edna M Wolfe Reisterstown Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
434.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure - Chronic</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 8, 1956</u> , to <u>Aug 9, 1957</u> , that I last saw the deceased alive on <u>Aug 9, 1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Williams Jr.</u>		DATE THEREOF <u>Aug 13 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		LOCATION (City, town, or county) <u>Uniontown Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 13 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		LOCATION (City, town, or county) <u>Uniontown Md</u>	
24. REC'D BY REGISTRAR <u>Mary B. Elmer</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman & Sons</u>		ADDRESS <u>Reisterstown Md</u>	
DATE <u>8-12-57</u>							

RECEIVED

1
The following information was furnished by the Bureau of Health Statistics, State of Maryland, on August 15, 1957, in response to a request for information regarding the death of [Name Redacted] on [Date Redacted] at [Location Redacted].

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DEATH		2. SEX		3. AGE	
[Name Redacted]		[Sex Redacted]		[Age Redacted]	
4. DATE OF DEATH		5. PLACE OF DEATH		6. CAUSE OF DEATH	
[Date Redacted]		[Place Redacted]		[Cause Redacted]	
7. PLACE OF BIRTH		8. PLACE OF DEATH		9. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
10. DATE OF BIRTH		11. DATE OF DEATH		12. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
13. PLACE OF BIRTH		14. PLACE OF DEATH		15. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
16. DATE OF BIRTH		17. DATE OF DEATH		18. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
19. PLACE OF BIRTH		20. PLACE OF DEATH		21. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
22. DATE OF BIRTH		23. DATE OF DEATH		24. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
25. PLACE OF BIRTH		26. PLACE OF DEATH		27. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
28. DATE OF BIRTH		29. DATE OF DEATH		30. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
31. PLACE OF BIRTH		32. PLACE OF DEATH		33. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
34. DATE OF BIRTH		35. DATE OF DEATH		36. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
37. PLACE OF BIRTH		38. PLACE OF DEATH		39. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
40. DATE OF BIRTH		41. DATE OF DEATH		42. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
43. PLACE OF BIRTH		44. PLACE OF DEATH		45. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
46. DATE OF BIRTH		47. DATE OF DEATH		48. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
49. PLACE OF BIRTH		50. PLACE OF DEATH		51. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
52. DATE OF BIRTH		53. DATE OF DEATH		54. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
55. PLACE OF BIRTH		56. PLACE OF DEATH		57. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
58. DATE OF BIRTH		59. DATE OF DEATH		60. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
61. PLACE OF BIRTH		62. PLACE OF DEATH		63. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
64. DATE OF BIRTH		65. DATE OF DEATH		66. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
67. PLACE OF BIRTH		68. PLACE OF DEATH		69. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
70. DATE OF BIRTH		71. DATE OF DEATH		72. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
73. PLACE OF BIRTH		74. PLACE OF DEATH		75. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
76. DATE OF BIRTH		77. DATE OF DEATH		78. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
79. PLACE OF BIRTH		80. PLACE OF DEATH		81. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
82. DATE OF BIRTH		83. DATE OF DEATH		84. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
85. PLACE OF BIRTH		86. PLACE OF DEATH		87. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
88. DATE OF BIRTH		89. DATE OF DEATH		90. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
91. PLACE OF BIRTH		92. PLACE OF DEATH		93. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
94. DATE OF BIRTH		95. DATE OF DEATH		96. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	
97. PLACE OF BIRTH		98. PLACE OF DEATH		99. MANNER OF DEATH	
[Place Redacted]		[Place Redacted]		[Manner Redacted]	
100. DATE OF BIRTH		101. DATE OF DEATH		102. MANNER OF DEATH	
[Date Redacted]		[Date Redacted]		[Manner Redacted]	

BUREAU V. 2

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08240

08251

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 9yrlmth3dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y61-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3216 Foster Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martin J. Brandt				4. DATE OF DEATH Month Day Year August 30, 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sea food dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Brandt				14. MOTHER'S MAIDEN NAME Margaret Fuchs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9027 DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular disease (c) fracture left hip femur 1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e) 7-18-57 Reduction and insertion of knee pin 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell while getting out of bed on 6-12-57 sustaining a sub-capital fracture of the left hip 20c. TIME OF INJURY Month, Day, Year 5:00 a.m. 6-12 1957 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital 20f. (City or town) (County) (State) Catonsville 28, Maryland							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aug 30 57			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-2 -57.		22c. NAME OF CEMETERY OR CREMATORY SACKED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Gailer				ADDRESS 901 S. CONKLING ST. BALTO., 24, MD		24a. REC'D BY REGISTRAR SEP 3 '57	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DEPT.
FOR STATE

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1951

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		10/15/51		Home	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Medical History		Previous Illnesses		Family History		Social History		Habitual Drugs	
Hypertension		None		None		None		None	
Autopsy		Postmortem		Burial		Disposition of Body		Remarks	
Yes		Yes		Yes		Yes		None	
Signature of Examiner		Signature of Coroner		Signature of Registrar		Signature of Physician		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Burial		Date of Disposition		Date of Return		Date of Final Report	
10/15/51		10/15/51		10/15/51		10/15/51		10/15/51	

BUREAU V. B.

SEP 4 1957

RECEIVED

08252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2519 Hillford Drive</u>				d. STREET ADDRESS <u>2519 Hillford Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>M</u> Middle <u>Betty</u> Last <u>M. Burns</u>				4. DATE OF DEATH Month <u>August</u> Day <u>23rd</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 23, 1906</u>	
9. AGE (In years last birthday) <u>50 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Phyles</u>				14. MOTHER'S MAIDEN NAME <u>Alice Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Dolores Lentz, 2519 Hillford Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Malignant lymphoma</u> DUE TO (c) <u>1 yr.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>50</u> , to <u>August 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 22</u> , 19 <u>57</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Carr, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>6201 York Road</u>		DATE SIGNED <u>8/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Charles E. Carr, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>AUG 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 27 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED]

3. AGE: [REDACTED]

4. DATE OF BIRTH: [REDACTED]

5. PLACE OF BIRTH: [REDACTED]

6. OCCUPATION: [REDACTED]

7. CAUSE OF DEATH: [REDACTED]

8. PLACE OF DEATH: [REDACTED]

9. DATE OF DEATH: [REDACTED]

10. SIGNATURE OF DECEASED: [REDACTED]

11. SIGNATURE OF WITNESS: [REDACTED]

12. SIGNATURE OF PHYSICIAN: [REDACTED]

13. SIGNATURE OF CORONER: [REDACTED]

14. SIGNATURE OF REGISTRAR: [REDACTED]

15. SIGNATURE OF CLERK: [REDACTED]

16. SIGNATURE OF [REDACTED]: [REDACTED]

17. SIGNATURE OF [REDACTED]: [REDACTED]

18. SIGNATURE OF [REDACTED]: [REDACTED]

19. SIGNATURE OF [REDACTED]: [REDACTED]

20. SIGNATURE OF [REDACTED]: [REDACTED]

21. SIGNATURE OF [REDACTED]: [REDACTED]

22. SIGNATURE OF [REDACTED]: [REDACTED]

23. SIGNATURE OF [REDACTED]: [REDACTED]

24. SIGNATURE OF [REDACTED]: [REDACTED]

25. SIGNATURE OF [REDACTED]: [REDACTED]

26. SIGNATURE OF [REDACTED]: [REDACTED]

27. SIGNATURE OF [REDACTED]: [REDACTED]

28. SIGNATURE OF [REDACTED]: [REDACTED]

29. SIGNATURE OF [REDACTED]: [REDACTED]

30. SIGNATURE OF [REDACTED]: [REDACTED]

31. SIGNATURE OF [REDACTED]: [REDACTED]

32. SIGNATURE OF [REDACTED]: [REDACTED]

33. SIGNATURE OF [REDACTED]: [REDACTED]

34. SIGNATURE OF [REDACTED]: [REDACTED]

35. SIGNATURE OF [REDACTED]: [REDACTED]

36. SIGNATURE OF [REDACTED]: [REDACTED]

37. SIGNATURE OF [REDACTED]: [REDACTED]

38. SIGNATURE OF [REDACTED]: [REDACTED]

39. SIGNATURE OF [REDACTED]: [REDACTED]

40. SIGNATURE OF [REDACTED]: [REDACTED]

41. SIGNATURE OF [REDACTED]: [REDACTED]

42. SIGNATURE OF [REDACTED]: [REDACTED]

43. SIGNATURE OF [REDACTED]: [REDACTED]

44. SIGNATURE OF [REDACTED]: [REDACTED]

45. SIGNATURE OF [REDACTED]: [REDACTED]

46. SIGNATURE OF [REDACTED]: [REDACTED]

47. SIGNATURE OF [REDACTED]: [REDACTED]

48. SIGNATURE OF [REDACTED]: [REDACTED]

49. SIGNATURE OF [REDACTED]: [REDACTED]

50. SIGNATURE OF [REDACTED]: [REDACTED]

51. SIGNATURE OF [REDACTED]: [REDACTED]

52. SIGNATURE OF [REDACTED]: [REDACTED]

53. SIGNATURE OF [REDACTED]: [REDACTED]

54. SIGNATURE OF [REDACTED]: [REDACTED]

55. SIGNATURE OF [REDACTED]: [REDACTED]

56. SIGNATURE OF [REDACTED]: [REDACTED]

57. SIGNATURE OF [REDACTED]: [REDACTED]

58. SIGNATURE OF [REDACTED]: [REDACTED]

59. SIGNATURE OF [REDACTED]: [REDACTED]

60. SIGNATURE OF [REDACTED]: [REDACTED]

61. SIGNATURE OF [REDACTED]: [REDACTED]

62. SIGNATURE OF [REDACTED]: [REDACTED]

63. SIGNATURE OF [REDACTED]: [REDACTED]

64. SIGNATURE OF [REDACTED]: [REDACTED]

65. SIGNATURE OF [REDACTED]: [REDACTED]

66. SIGNATURE OF [REDACTED]: [REDACTED]

67. SIGNATURE OF [REDACTED]: [REDACTED]

68. SIGNATURE OF [REDACTED]: [REDACTED]

69. SIGNATURE OF [REDACTED]: [REDACTED]

70. SIGNATURE OF [REDACTED]: [REDACTED]

71. SIGNATURE OF [REDACTED]: [REDACTED]

72. SIGNATURE OF [REDACTED]: [REDACTED]

73. SIGNATURE OF [REDACTED]: [REDACTED]

74. SIGNATURE OF [REDACTED]: [REDACTED]

75. SIGNATURE OF [REDACTED]: [REDACTED]

76. SIGNATURE OF [REDACTED]: [REDACTED]

77. SIGNATURE OF [REDACTED]: [REDACTED]

78. SIGNATURE OF [REDACTED]: [REDACTED]

79. SIGNATURE OF [REDACTED]: [REDACTED]

80. SIGNATURE OF [REDACTED]: [REDACTED]

81. SIGNATURE OF [REDACTED]: [REDACTED]

82. SIGNATURE OF [REDACTED]: [REDACTED]

83. SIGNATURE OF [REDACTED]: [REDACTED]

84. SIGNATURE OF [REDACTED]: [REDACTED]

85. SIGNATURE OF [REDACTED]: [REDACTED]

86. SIGNATURE OF [REDACTED]: [REDACTED]

87. SIGNATURE OF [REDACTED]: [REDACTED]

88. SIGNATURE OF [REDACTED]: [REDACTED]

89. SIGNATURE OF [REDACTED]: [REDACTED]

90. SIGNATURE OF [REDACTED]: [REDACTED]

91. SIGNATURE OF [REDACTED]: [REDACTED]

92. SIGNATURE OF [REDACTED]: [REDACTED]

93. SIGNATURE OF [REDACTED]: [REDACTED]

94. SIGNATURE OF [REDACTED]: [REDACTED]

95. SIGNATURE OF [REDACTED]: [REDACTED]

96. SIGNATURE OF [REDACTED]: [REDACTED]

97. SIGNATURE OF [REDACTED]: [REDACTED]

98. SIGNATURE OF [REDACTED]: [REDACTED]

99. SIGNATURE OF [REDACTED]: [REDACTED]

100. SIGNATURE OF [REDACTED]: [REDACTED]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

08242

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 13	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sue Island Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Yacht Club		d. STREET ADDRESS 3139 Clifftmont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edwin Taylor Busch		4. DATE OF DEATH August 4 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1904
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar Busch		14. MOTHER'S MAIDEN NAME Anna M. Schuster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-2789	
17. INFORMANT Mrs. Madeline Busch, 3139 Clifftmont Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack C. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack C. Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-57	
22c. NAME OF CEMETERY OR CREMATORY Morland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR 8/8/57		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John H. [illegible]		Sex Male		Age [illegible]	
Residence [illegible]		Occupation [illegible]		Date of Death [illegible]	
Cause of Death [illegible]		Manner of Death [illegible]		Place of Death [illegible]	
Signature of Medical Examiner [illegible]		Signature of Coroner [illegible]		Signature of [illegible]	
Address of Medical Examiner [illegible]		Address of Coroner [illegible]		Address of [illegible]	

BUREAU V. S.

AUG 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08254

CERTIFICATE OF DEATH

Reg. Dist. No.

082438

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>37</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEIGHTON O. BYERS</u>		4. DATE OF DEATH <u>Aug 12</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7-1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Byers</u>		14. MOTHER'S MAIDEN NAME <u>Betty Roller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-9123</u>	
17. INFORMANT <u>Mrs L O Byers</u>		Address <u>7221 Rolden Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obstruction of common bile duct</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Chronic pancreatitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-7 mo</u> <u>2 mo</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-10-57</u> to <u>8-12-57</u> , that I last saw the deceased alive on <u>8-10-57</u> 19 <u>57</u> , and that death occurred at <u>11:30</u> M, from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>James G. Saffell</u> M.D.		DATE SIGNED <u>8-13-57</u>	
PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>		ADDRESS (Street, city or town, state) <u>Reisterstown Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 15-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woods</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Burns Sons - Towson 4</u>		24a. REC'D BY REGISTRAR DATE <u>8/14/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>E. A. M. Bacon</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF RESIDENCE		COUNTY OF RESIDENCE		STATE OF RESIDENCE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		ARMY SERVICE		AIR FORCE SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE			
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. 3

AUG 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 0824421										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2613 Royal Oak Ave.					d. STREET ADDRESS 2613 Royal Oak Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last BYRNE					4. DATE OF DEATH Month Aug. Day 1, Year 19 57					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1876		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William B. Anthony					14. MOTHER'S MAIDEN NAME Amelia V. Poole					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. W. Frank Reed - 522 Equitable Bldg.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 8/5/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. Md.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baeto 17					24a. REC'D BY REGISTRAR DATE 8/6/57		24b. REGISTRAR'S SIGNATURE Dr. M. M. Martin			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten and stamped information.

RECEIVED
AUG 7 1957
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

082456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PROSPECT PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PROSPECT PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LIFE</u>		d. STREET ADDRESS <u>RIVERSIDE Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>EARL D. CALLIGAN</u>		4. DATE OF DEATH <u>8-3-1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12 - 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS CALLIGAN</u>		14. MOTHER'S MAIDEN NAME <u>DINS MORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>LAURA SAVERS</u>	
17. INFORMANT <u>LAURA SAVERS</u>		Address <u>5707 BELAIR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND'S</u>		22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly - Esq. Md.</u>		24a. REC'D BY REGISTRAR <u>150</u> DATE <u>8/5/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Edith Turley</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, date of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. 2

JUG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08257

CERTIFICATE OF DEATH

08246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>				c. LENGTH OF STAY IN 1b <u>17 mos.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u> <u>13 x 02</u>				d. STREET ADDRESS <u>Route 96</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hosniece</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Dickey</u> Last <u>Carmack</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1877</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Dickey</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Page Needham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-34-6049</u>		17. INFORMANT <u>Admission Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>10 YRS.</u> (c) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>Aug.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 16</u> , 19 <u>57</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Timonium, MD</u> DATE SIGNED <u>8/16/57</u> ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Antonia</u>	

4905 York Road - Balto. 12, Md.

BUREAU V. 5

Aug 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0824738

08258

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson - Balto. 4 Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice, Towson-Balto. 4 Maryland</u>				d. STREET ADDRESS <u>Knights of Columbus-Cathedral & Madison Streets</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Valentine Carver</u>				4. DATE OF DEATH Month Day Year <u>8 26 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1870</u>	9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Position</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Carver</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Daphin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Miss Helen Nottingham 10 E. 33rd. Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure, Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure, Chronic</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months & Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cerebrovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug 25</u> , 19 <u>57</u> to <u>Aug 26</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>57</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard W. Blide</u>				ADDRESS (Street, city or town, state) <u>7501 York Rd. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard W. Blide- M.D.</u>				DATE SIGNED <u>7501 York Road, Baltimore, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Means & Son 8057 Calvert St.</u>				24. RECEIVED BY REGISTRAR DATE <u>AUG 29 1957</u>			
25. REGISTRAR'S SIGNATURE <u>Matel Grey</u>				26. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
LABORER		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		BALTIMORE		BALTIMORE	

BUREAU V. 1

AUG 29 1957

RECEIVED

08235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
c. LENGTH OF STAY IN <u>4 yrs</u>		51 <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1250 Sulphur Spring Rd</u>		d. STREET ADDRESS <u>1250 Sulphur Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Mary</u> <u>Middle</u> <u>E.</u> <u>Last</u> <u>Baronaukh</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1890</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Manor, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Rowles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT <u>Mrs. Laura G. DeBoy</u>		Address <u>1250 Sulphur Spring Rd</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma both breasts</u> <u>170x</u> DUE TO <u>Extensive carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chr myocardiitis</u> DUE TO <u>hypertension</u> (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>10 yrs</u> <u>6 mo</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>7</u> , 1942, to <u>Aug 15</u> , 1957, that I last saw the deceased alive on <u>Aug 14</u> , 1947, and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <u>B B Baronaukh, M.D.</u>	<u>8/16/57</u>
PHYSICIAN'S NAME (Type) <u>B B Baronaukh, M.D.</u>	<u>Ed Bridge 27</u>

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodward Ave</u>	22d. LOCATION (City, town, or county) (State) <u>Storsey, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Long</u>		ADDRESS <u>301 S. Line St</u>	
24a. REC'D BY REGISTRAR <u>Dr. Geo. M. Kuffner</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kuffner</u>	

BUREAU V. 3

AUG 19 1957

RECEIVED

08259

CERTIFICATE OF DEATH

08249

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Stevenson</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>Halcyon Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>—</u> Last <u>Cockey</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Parks</u>			14. MOTHER'S MAIDEN NAME <u>Doshia Chalk</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. Elmer F. Cockey, Stevenson, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DIFFUSE BRONCHOPNEUMONIA</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u> <u>PARKINSONISM</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>2/4</u> , 19 <u>57</u> , to <u>8/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>57</u> , and that death occurred at <u>10:25 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Samuel P. Scalia</u>		ADDRESS (Street, city or town, state) <u>1331 REISTERSTOWN ROAD</u>		DATE SIGNED <u>8/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Samuel P. Scalia, M.D.</u>		<u>PIKESVILLE 8 MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Pikesville, Md</u>		ADDRESS <u>1331 REISTERSTOWN ROAD</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 13, 14, Film C220 9-11-57 et

CERTIFICATE OF DEATH

08227

Reg. Dist. No.

0825041

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>0012 PATAPSCO AVE</u>				d. STREET ADDRESS <u>112 PATAPSCO AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>R.</u> Last <u>COHN.</u>				4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 JUNE, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHARMACIST</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-32-4827</u>		17. INFORMANT <u>GENEVIEVE E. COHN - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				(County) <u> </u>			
(State) <u> </u>				21. I certify that I attended the deceased from <u>June 2, 1957</u> , to <u>Aug 27, 1957</u> , that I last saw the deceased alive on <u>Aug 27, 1957</u> , and that death occurred at <u>11:59 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. Barker</u> M.D.				DATE SIGNED <u>3479 Liberty Hwy</u>			
PHYSICIAN'S NAME (Type) <u> </u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>8/1</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Bradley, Dundalk, Md.</u>				24. REC'D BY REGISTRAR <u>AUG 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JULY 1, 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		CITY OF RESIDENCE	
Attorney		Memphis, Tenn.	
PLACE OF DEATH		CAUSE OF DEATH	
St. Louis, Mo.		Suicide by gunshot	
MANNER OF DEATH		IMMEDIATE CAUSE OF DEATH	
Natural		Gunshot wound	
DISEASE OR INJURY		MORBIDITY	
Suicide		Suicide	
DATE OF BIRTH		PLACE OF BIRTH	
JANUARY 5, 1933		Memphis, Tenn.	
FATHER'S NAME		MOTHER'S NAME	
JAMES EARL RAY, JR.		JAMES EARL RAY, JR.	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
Attorney		Homemaker	
FATHER'S ADDRESS		MOTHER'S ADDRESS	
1000 ...		1000 ...	
FATHER'S PHONE		MOTHER'S PHONE	
...		...	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE	
JAMES EARL RAY, JR.		JAMES EARL RAY, JR.	
FATHER'S TITLE		MOTHER'S TITLE	
Attorney		Homemaker	
FATHER'S RELIGION		MOTHER'S RELIGION	
Protestant		Protestant	
FATHER'S ETHNICITY		MOTHER'S ETHNICITY	
White		White	
FATHER'S NATIONALITY		MOTHER'S NATIONALITY	
American		American	
FATHER'S CITIZENSHIP		MOTHER'S CITIZENSHIP	
Naturalized		Naturalized	
FATHER'S STATUS		MOTHER'S STATUS	
Married		Married	
FATHER'S RELIGIOUS BELIEFS		MOTHER'S RELIGIOUS BELIEFS	
Protestant		Protestant	
FATHER'S POLITICAL BELIEFS		MOTHER'S POLITICAL BELIEFS	
Republican		Republican	
FATHER'S SOCIAL BELIEFS		MOTHER'S SOCIAL BELIEFS	
Conservative		Conservative	
FATHER'S ECONOMIC BELIEFS		MOTHER'S ECONOMIC BELIEFS	
Capitalist		Capitalist	
FATHER'S CULTURAL BELIEFS		MOTHER'S CULTURAL BELIEFS	
American		American	
FATHER'S EDUCATIONAL BELIEFS		MOTHER'S EDUCATIONAL BELIEFS	
High School		High School	
FATHER'S PROFESSIONAL BELIEFS		MOTHER'S PROFESSIONAL BELIEFS	
Attorney		Homemaker	
FATHER'S ARTISTIC BELIEFS		MOTHER'S ARTISTIC BELIEFS	
No		No	
FATHER'S SCIENTIFIC BELIEFS		MOTHER'S SCIENTIFIC BELIEFS	
No		No	
FATHER'S PHILOSOPHICAL BELIEFS		MOTHER'S PHILOSOPHICAL BELIEFS	
No		No	
FATHER'S RELIGIOUS BELIEFS		MOTHER'S RELIGIOUS BELIEFS	
Protestant		Protestant	
FATHER'S POLITICAL BELIEFS		MOTHER'S POLITICAL BELIEFS	
Republican		Republican	
FATHER'S SOCIAL BELIEFS		MOTHER'S SOCIAL BELIEFS	
Conservative		Conservative	
FATHER'S ECONOMIC BELIEFS		MOTHER'S ECONOMIC BELIEFS	
Capitalist		Capitalist	
FATHER'S CULTURAL BELIEFS		MOTHER'S CULTURAL BELIEFS	
American		American	
FATHER'S EDUCATIONAL BELIEFS		MOTHER'S EDUCATIONAL BELIEFS	
High School		High School	
FATHER'S PROFESSIONAL BELIEFS		MOTHER'S PROFESSIONAL BELIEFS	
Attorney		Homemaker	
FATHER'S ARTISTIC BELIEFS		MOTHER'S ARTISTIC BELIEFS	
No		No	
FATHER'S SCIENTIFIC BELIEFS		MOTHER'S SCIENTIFIC BELIEFS	
No		No	
FATHER'S PHILOSOPHICAL BELIEFS		MOTHER'S PHILOSOPHICAL BELIEFS	
No		No	

BUREAU V. 8

AUG 30 1967

RECEIVED

THIS IS A COPY OF THE ORIGINAL RECORD AND IS NOT TO BE REPRODUCED OR USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE RETURNED TO THE OFFICE OF RECORDS AND COMMUNICATIONS, 1000 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08260

CERTIFICATE OF DEATH

08251 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 74 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) THOMAS		First A.		Middle COLE		Last COLE	
4. DATE OF DEATH AUGUST		Month 10		Day 19		Year 57	
5. SEX MALE		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-2-89	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) BALTIMORE CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET CLEANER				10b. KIND OF BUSINESS OR INDUSTRY for Baltimore City			
13. FATHER'S NAME JOSEPH COLE				14. MOTHER'S MAIDEN NAME ELIZABETH Willalea			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5720 POST OPERATIVE STATUS-ILEO-TRANSVERSE COLOSTOMY DUE TO REGIONAL ILEITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DEHISCENCE OF ABDOMINAL WOUND - 6-6-57							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from May 28 19 57 to August 10 19 57 and that death occurred at 6:02 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8-10-57 ACTUAL SIGNATURE T. Lawrence Fleisher PHYSICIAN'S NAME (Type) T. LAWRENCE FLEISHER M.D. VAH, FORT HOWARD, MARYLAND 8-10-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/13/57		22c. NAME OF CEMETERY OR CREMATORY NEW CATHADRAL CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Son JOHN J. COWAN & SON HOLLINS & POPPLETON STS., BALTIMORE, MD.				24a. REC'D BY REGISTRAR Aug 12 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Harley	

CERTIFICATE OF DEATH

NAME OF DECEASED PORT HANCOCK		AGE 74 DAYS		SEX MALE		RACE WHITE	
PLACE OF BIRTH BALTIMORE		DATE OF BIRTH AUGUST 28 1967		DATE OF DEATH AUGUST 28 1967		PLACE OF DEATH BALTIMORE	
HOSPITAL ST. JOSEPH'S HOSPITAL		PHYSICIAN DR. J. J. HARRIS		CAUSE OF DEATH SIDS		MANNER OF DEATH NATURAL	
RESIDENT OF 2015 GARY DRIVE		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND	
OCCUPATION CLEANER		EDUCATION HIGH SCHOOL		RELIGION CATHOLIC		MARRIAGE M-1	
FATHER'S NAME J. J. HARRIS		MOTHER'S NAME M. J. HARRIS		FATHER'S OCCUPATION CLEANER		MOTHER'S OCCUPATION HOUSEWIFE	
FATHER'S ADDRESS BALTIMORE CO. MARYLAND		MOTHER'S ADDRESS BALTIMORE CO. MARYLAND		FATHER'S PHONE BALTIMORE		MOTHER'S PHONE BALTIMORE	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES	
FATHER'S TITLE		MOTHER'S TITLE		DECEASED'S TITLE		WITNESSES' TITLES	
FATHER'S RELATIONSHIP		MOTHER'S RELATIONSHIP		DECEASED'S RELATIONSHIP		WITNESSES' RELATIONSHIPS	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		DECEASED'S RESIDENCE		WITNESSES' RESIDENCES	
FATHER'S PHONE		MOTHER'S PHONE		DECEASED'S PHONE		WITNESSES' PHONES	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES	
FATHER'S TITLE		MOTHER'S TITLE		DECEASED'S TITLE		WITNESSES' TITLES	
FATHER'S RELATIONSHIP		MOTHER'S RELATIONSHIP		DECEASED'S RELATIONSHIP		WITNESSES' RELATIONSHIPS	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		DECEASED'S RESIDENCE		WITNESSES' RESIDENCES	
FATHER'S PHONE		MOTHER'S PHONE		DECEASED'S PHONE		WITNESSES' PHONES	

RECEIVED
AUG 12 1967
BUREAU K. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08261

CERTIFICATE OF DEATH

08252/4

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b 35 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sparrows Pt. Rt. 10 Box 320A				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beulah Middle H. Last Collins				4. DATE OF DEATH Month Aug. Day 15, Year 19 57			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.	IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Edgar Hannon				14. MOTHER'S MAIDEN NAME Betty Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Rowena Hammond, Sparrows Pt. Box 320 A.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 170x DUE TO Carcinoma of Breast, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs. (c) 3 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1957 , to Aug 15, 1957 , that I last saw the deceased alive on Aug 13, 1957 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Windsor				ADDRESS (Street, city or town, state) 520 D St. SP 19			
DATE SIGNED 8/16/57				DATE SIGNED			
PHYSICIAN'S NAME (Type) ROGER G WINDSOR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave				24a. REC'D BY REGISTRAR 8/20/57		24b. REGISTRAR'S SIGNATURE L. L. Lark	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. THOMAS—WISH TO TRANSFER TO STATE CHAIRMAN

AUG 20 1957

RECEIVED

08262

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>7 weeks 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3001-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Armco Nursing Home, Sherwood & Register Ave</u>				d. STREET ADDRESS <u>1547 Kings way Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lee</u> Last <u>Combs Sr.</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u>22</u> Min. <u>30</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer of Uniforms</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nurses Uniform Co</u>		11. BIRTHPLACE (State or foreign country) <u>St. Marys County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>George W. Combs</u>				14. MOTHER'S MAIDEN NAME <u>Martha Fowler Combs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-22-8612</u>		17. INFORMANT <u>Joseph L. Combs Jr</u> Address <u>5529 Hillen Rd Balto 12 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>Aug 29, 1957</u> that I last saw the deceased alive on <u>Aug 29, 1957</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald W. Mintzer</u> M.D.				ADDRESS (Street, city or town, state) <u>3009 EVERGREEN AVE</u> DATE SIGNED <u>Aug 30 1957</u>			
PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>				<u>BALTIMORE 14 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND PK</u>		22d. LOCATION (City, town, or county) (State) <u>TAYLOR AVE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO H LEIMBACH</u> ADDRESS <u>525 LYNDSBURST ST</u>				24a. REC'D BY REGISTRAR DATE <u>3</u> 1957		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 3 1957

RECEIVED

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Md b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE		c. LENGTH OF STAY in 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4136 Lincoln Ave.				d. STREET ADDRESS 4136 Lincoln Av		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROYAL Middle HENRY Last COMES				4. DATE OF DEATH Month August Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14, 1897		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Comes				14. MOTHER'S MAIDEN NAME Susan J. Chenoweth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-30-3273		17. INFORMANT Mrs. Marie E. Comes Address 4136 Lincoln Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic coronary artery disease (a), stating the underlying cause last. DUE TO (c) 420.1						INTERVAL BETWEEN ONSET AND DEATH approx 3hrs undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-26-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home				24a. REC'D BY REGISTRAR AUG 20 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Rysomley	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JOHN J. ...		...		...		...		...		...		...		...		...		...
MARRIAGE		...		...		...		...		...		...		...		...		...
EDUCATION		...		...		...		...		...		...		...		...		...
OCCUPATION		...		...		...		...		...		...		...		...		...
CAUSE OF DEATH		...		...		...		...		...		...		...		...		...
MANNER OF DEATH		...		...		...		...		...		...		...		...		...
SIGNATURE OF EXAMINER		...		...		...		...		...		...		...		...		...
DATE		...		...		...		...		...		...		...		...		...

BUREAU V. 2

AUG 29 1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08236

CERTIFICATE OF DEATH

Reg. Dist. No.

0825547

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4322 Ridge Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William E. Council</u>		4. DATE OF DEATH Month Day Year <u>August 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTH PLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Lucy F. Council 4322 Ridge Ave.</u>	
17. INFORMANT <u>Lucy F. Council 4322 Ridge Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Essential Hypertension</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 25, 1955</u> to <u>Aug 1, 1957</u> , that I last saw the deceased alive on <u>12/15/57</u> , 19 <u>57</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Arthur Rossberg</u> M.D.		ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore 30 Md.</u>	
DATE SIGNED <u>Aug 3, 1957</u>		DATE SIGNED <u>Aug 5 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey Howard Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ammon, Inc 1328 Sulphur Spring Rd.</u>		ADDRESS <u>Ammon, Inc 1328 Sulphur Spring Rd.</u>	
24a. REC'D BY REGISTRAR <u>AUG 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kuffner</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

AUG 5 1957

RECEIVED

08264

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MD. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7 yrs.			
d. NAME OF HOSPITAL (If in hospital) (If not address) Shady Nook Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL (If in hospital) (If not address) Shady Nook Nursing Home				d. STREET ADDRESS 230 Mallow Hill Road			
3. NAME OF DECEASED (Type or print) First M. Middle Elsie Last Crew				4. DATE OF DEATH Month August Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1887	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Newton Enos				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT Mrs. Clarence Stoner, Niece, 603 Plymouth Rd			
16. SOCIAL SECURITY NO.				14. MOTHER'S MAIDEN NAME Alice----			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Discompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 wks. 20 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 7, 1950 , to August 2, 1957 , that I last saw the deceased alive on August 1, 1957 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore 28, Md. DATE SIGNED 8-3-57							
ACTUAL SIGNATURE Wilmer K. Gallagher				M.D. 6209 Frederick Ave. Baltimore 28, Md.			
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher				ADDRESS Baltimore 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5/57		22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson				24. REC'D BY REGISTRAR Aug 7 57		24. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. E.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 12
11-23-57

CERTIFICATE OF DEATH

NAME OF DECEASED
JAMES EARL RAY

DATE OF DEATH
JULY 17, 1957

PLACE OF DEATH
BALTIMORE, MARYLAND

AGE
35

SEX
MALE

RACE
WHITE

EDUCATION
HIGH SCHOOL

OCCUPATION
BUSINESSMAN

CAUSE OF DEATH
HEART DISEASE

DATE OF BURIAL
JULY 19, 1957

PLACE OF BURIAL
BALTIMORE, MARYLAND

SIGNATURE OF DECEASED
JAMES EARL RAY

SIGNATURE OF WITNESSES
JAMES EARL RAY

SIGNATURE OF PHYSICIAN
JAMES EARL RAY

SIGNATURE OF CLERK
JAMES EARL RAY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 6219 8-14-57 et

08257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Hospital				d. STREET ADDRESS 3329 Beech Ave.			
3. NAME OF DECEASED (Type or print) First ANDREW Middle JOSEPH Last CUNNINGHAM				4. DATE OF DEATH Month August Day 5 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPET WEAVER		10b. KIND OF BUSINESS OR INDUSTRY RUG CO.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Cunningham				14. MOTHER'S MAIDEN NAME Harrorah O'Meara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217 12 7278		17. INFORMANT Mrs. M. M. Coughlin, 4600 Pall Mall Rd. Balto. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 443 x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH 8 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> ONE		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. DAVIS, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED 8/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon				ADDRESS 4611 Park Heights, Balto.		24a. REC'D BY REGISTRAR Aug 7 1957	
				24b. REGISTRAR'S SIGNATURE Dawson L. Harber			

08266

CERTIFICATE OF DEATH

08258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Stevenson Lane				d. STREET ADDRESS 216 Stevenson Lane			
3. NAME OF DECEASED (Type or print) First DONALD Middle H. Last DASHIELL				4. DATE OF DEATH Month Aug. Day 25 , Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1917	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Paul H. Dashiell				14. MOTHER'S MAIDEN NAME Nellie Lessner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War II		17. INFORMANT Mrs. Gloria Dashiell -216 Stevenson Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Left Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 57 , to Aug 25 , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 4:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Laurence C. Post M.D.				ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md.			
PHYSICIAN'S NAME (Type) LAURENCE C. Post				DATE SIGNED Aug 27 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekener & Sons				24a. REC'D BY REGISTRAR Aug 27 1957			
ADDRESS Balto 17 Md				24b. REGISTRAR'S SIGNATURE Michel Grey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF MINISTERS		23. SIGNATURE OF MUSICIANS		24. SIGNATURE OF FLORISTS	
25. SIGNATURE OF COFFIN MAKERS		26. SIGNATURE OF CARRIAGE DRIVERS		27. SIGNATURE OF BELL RINGERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	

RECEIVED

BUREAU V. 3

AUG 23 1957

RECEIVED

08267

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	c. LENGTH OF STAY IN 1b <u>40 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd</u>		d. STREET ADDRESS <u>York Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Frances</u> Last <u>Daughton</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Sept 1885</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Causion</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Venable</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Husband</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease 34rs</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>146</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 49</u> , 19 <u>57</u> , to <u>Aug 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>17 August</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>17 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cockeysville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevenson Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Sparks Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u>		ADDRESS <u>Funeral Home Inc.</u>	
24a. REC'D BY REGISTRAR <u>Aug 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ely Gonsky</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1957

RECEIVED

08268

CERTIFICATE OF DEATH

Reg. Dist. No.

08268

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IB 3mtnsl4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Md. 02X02	
3. NAME OF DECEASED (Type or print) First Ida Middle BACKHOFF Last P. Davis		4. DATE OF DEATH Month Aug. Day 4 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	11. IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXXXX Charles Burgraf		14. MOTHER'S MAIDEN NAME XXXXXXXX Anna A. Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-3448	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CV A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AORTITIS DUE TO (c) LUES		INTERVAL BETWEEN ONSET AND DEATH 7/15/57 8/3/57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1957 , to AUGUST 3, 1957 , that I last saw the deceased alive on AUGUST 3, 1957 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE David E. Edwards M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) DAVID E. EDWARDS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons		24a. REC'D BY REGISTRAR DATE AUG 9 '57	
ADDRESS Wm. J. Tichenor & Sons		24b. REGISTRAR'S SIGNATURE David E. Edwards	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

AUG 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2011 Russell Ave.		d. STREET ADDRESS 2011 Russell Ave.	
3. NAME OF DECEASED (Type or print) First LYDIA Middle F. Last DEATEL		4. DATE OF DEATH Month Aug. Day 29, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 Apr. 28, 1881
9. AGE (In years last birthday) 75 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME August Haupt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Charles A. Deatel - 2011 Russell Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/1 1957 , to 8/11 1957 , that I last saw the deceased alive on 8/1 1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton Schlenoff M.D.		ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd.	
PHYSICIAN'S NAME (Type) Milton Schlenoff		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/3/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vicknery		24a. REC'D BY REGISTRAR Wm. J. Vicknery	24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: **REAU V. S.**
 2. Sex: **M**
 3. Age: **4**
 4. Date of Birth: **SEP 4 1957**
 5. Place of Birth: **REAU V. S.**
 6. Date of Death: **SEP 4 1957**
 7. Time of Death: **10:00 AM**
 8. Cause of Death: **REAU V. S.**
 9. Place of Death: **REAU V. S.**
 10. Signature of Physician: **REAU V. S.**
 11. Signature of Registrar: **REAU V. S.**
 12. Date of Registration: **SEP 4 1957**

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08237

CERTIFICATE OF DEATH

08262 41
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN 1b <u>lifetime</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1250 Sulphur Spring Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton, MD 51</u> d. STREET ADDRESS <u>1250 Sulphur Spring Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>(DEBOY) PETER J. DEBOY</u>				4. DATE OF DEATH Month Day Year <u>Aug 8 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16 1876</u>	
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Restaur. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ferdinand De Boy</u>				14. MOTHER'S MAIDEN NAME <u>Therese Belts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-201944</u>			
17. INFORMANT <u>Mrs Elizabeth De Boy</u>				Address <u>1250 Sulphur Spring Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 8/8</u> , 19 <u>57</u> , to <u>8/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>57</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.				ADDRESS (Street, city or town, state) <u>5305 East Drive</u>			
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>				DATE SIGNED <u>8/10/57</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Aug 20 1957</u>				22b. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>		22c. LOCATION (City, town, or county) (State) <u>Fredrick, A. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Terleuda Ferry</u>				ADDRESS <u>5646 Carroll Ave</u>		24a. REC'D BY REGISTRAR <u>Dr. Gust M. Kueffer</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>AUG 14 1957</u>			

CERTIFICATE OF DEATH

08263

Reg. Dist. No.

08270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 11 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 1029 Myrtle Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First (ALSO: Matthew Dowell) Last MATTHEW (NMI) DOWELL				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/97	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Amos Dowell				14. MOTHER'S MAIDEN NAME Jane (MN: Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-05-4548		17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NECROTIC HEMORRHAGIC LESION OF THE PALATE AND PHARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CHRONIC LYMPHOCYTIC LEUKEMIA (c) 204.0 INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 26 , 19 57 , to August 6 , 19 57 , that I last saw the deceased alive on August 6 , 19 57 , and that death occurred at 5:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/8/57 ACTUAL SIGNATURE Chen Wei Lan M.D. PHYSICIAN'S NAME (Type) CHEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Charles R. Law Mortuary, 802-04 Madison Ave.				24a. REC'D BY REGISTRAR AUG 9 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

RECEIVED
AUG 9 1957
BUREAU V. 8

08271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 54 Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Co.		d. STREET ADDRESS 1 76 River Road	
3. NAME OF DECEASED (Type or print) First ERNEST Middle EDWIN Last EAGLE		4. DATE OF DEATH Month August Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-inn worker		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Eagle		14. MOTHER'S MAIDEN NAME Rosalie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Rosalie Baacke		Address 713 Brookwood Rd. Zone 29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema + Rib Fracture DUE TO (c) Acute Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 3 3 4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x Carcinoma of Prostate Gland			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1, 1957 to August 7, 1957 that I last saw the deceased alive on August 6, 1957 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Nelson McKay		M.D. 6014 Edmonson Ave Baltimore Md 8/8/57	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR Aug 12 1957	
ADDRESS Schimunek Funeral Home 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4

AUG 12 1961

BUREAU K. 8

RECEIVED

08272

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,				c. LENGTH OF STAY IN 1b 2½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4, 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Baltimore Ave.				d. STREET ADDRESS 203 Baltimore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARNOLD Middle JOHN Last EICHOLTZ				4. DATE OF DEATH Month AUGUST Day 26 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman				10b. KIND OF BUSINESS OR INDUSTRY Balto.Co.Hwys.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Eicholtz				14. MOTHER'S MAIDEN NAME Elizabeth Mumma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-9312		17. INFORMANT Mary C. Eicholtz		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS DUE TO (c) BRONCHOGENIC CARCINOMA WITH METASTASES							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 YEAR 18 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from APRIL 15, 1957 to AUGUST 26, 1957 , that I last saw the deceased alive on AUGUST 24, 1957 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald L. Somerville				ADDRESS (Street, city or town, state) 25 West Pennsylvania Avenue			
DATE SIGNED 8/26/57							
PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-57		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Long Green, Balto.Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS 622 York Rd. Towson 4, Md		24a. REC'D BY REGISTRAR Aug. 27, 1957	
				24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BUREAU OF VITAL RECORDS

1. NAME OF DECEASED JAMES J. CONNOLLY		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1912		5. PLACE OF BIRTH Boston, Mass.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE St. Mary's Church, Boston		10. NAME OF SPOUSE Mary E. Connelly	
11. DATE OF DEATH Aug 28, 1957		12. PLACE OF DEATH Home		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. SIGNATURE OF PHYSICIAN J. J. Connelly	
16. SIGNATURE OF DECEASED James J. Connelly		17. SIGNATURE OF WITNESSES John J. Connelly, Mary E. Connelly		18. SIGNATURE OF CLERK J. J. Connelly		19. SIGNATURE OF REGISTRAR J. J. Connelly		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary E. Connelly	

BUREAU V. B.

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

08273

CERTIFICATE OF DEATH

08266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yr.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Balto. 21 md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1630 Hopewell Ave.</u>				d. STREET ADDRESS <u>1 1630 Hopewell Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isabella</u> Middle <u>Epps</u> Last <u>Epps</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1957</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1892</u>		9. AGE (In years last birthday) <u>65 yr.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jasper Collier</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann?</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>William Epps</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x</u> <u>Uremia, coma</u> DUE TO <u>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart failure. Hypertension</u> DUE TO <u>10 days - severe</u> (c) <u>2 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 27, 1955</u> to <u>August 4, 1957</u> , that I last saw the deceased alive on <u>August 4, 1957</u> , and that death occurred at <u>5:50 P. M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>				ADDRESS (Street, city or town, state) <u>413 Eastern Ave., Essex, md.</u>				DATE SIGNED <u>8-6-57</u>			
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann, M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 8/57</u>				22b. DATE THEREOF <u>Aug 8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Calvary Cem.</u>		22d. LOCATION (City, town, or county) <u>aa. Crutcher md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Josiah P. Erickson</u>				ADDRESS <u>16297 Caroline St.</u>		24a. REC'D BY REGISTRAR <u>AUG 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Turkey</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 100-100

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY		19. SIGNATURE OF CHURCH		20. SIGNATURE OF OTHER	

BUREAU V. S.

AUG 9 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08274

CERTIFICATE OF DEATH

08267

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 1038 Stevens Rd.		e. STREET ADDRESS Box 1038 Stevens Rd.	
3. NAME OF DECEASED (Type or print) First John Middle James Last Farrell Sr.		4. DATE OF DEATH Month August Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 28, 1905
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	11. BIRTHPLACE (State or foreign country) Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Farrell	
14. MOTHER'S MAIDEN NAME Alma Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-05-4852		17. INFORMANT John J. Farrell Jr. Address Box 1038 Stevens Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of large bowel DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH less than 2 yrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/27 , 19 57 , to 8/5 , 19 57 , that I last saw the deceased alive on 8/4 , 19 57 , and that death occurred at 4:58 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Platt		ADDRESS (Street, city or town, state) 434 Eastern Ave DATE SIGNED	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.		Essex, md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 7, 1957	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	24. REC'D BY REGISTRAR AUG 6 1957 24b. REGISTRAR'S SIGNATURE Dr. Hatter

BUREAU V. S.

Aug 6 1957

RECEIVED

08268

08275
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 54 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (ALSO: CLYDE BUSH) CLAUD W FAWBUSH				4. DATE OF DEATH Month August Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/78	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Churchill, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Road Construction		11. BIRTHPLACE (State or foreign country) Churchill, Tennessee	
13. FATHER'S NAME Joseph Fawbush				14. MOTHER'S MAIDEN NAME Joanna Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes		16. SOCIAL SECURITY NO. 234-12-6598		17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERIOSCLEROSIS SEVERE WITH OLD MYOCARDIAL INFARCTIONS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) PULMONARY CONGESTION AND EDEMA DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7 YEARS UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 10 , 19 57 , to August 3 , 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 8/4/57 ACTUAL SIGNATURE Chien Wei Lan M.D. Fort Howard, Maryland PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc.				24a. REC'D BY REGISTRAR Aug 9 1957		24b. REGISTRAR'S SIGNATURE L. L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased Robert Howard		Date of Death 20 days		Place of Death Baltimore	
Age 30 years		Sex Male		Race White	
Marital Status Single		Occupation Lead Construction		Residence Glenville, Tennessee	
Cause of Death Lead Poisoning		Contributing Cause Lead Poisoning		Place of Burial Glenville, Tennessee	
Date of Burial 20 days		Place of Burial Glenville, Tennessee		Signature of Physician J. H. Smith	
Signature of Registrar J. H. Smith		Signature of Coroner J. H. Smith		Signature of Medical Examiner J. H. Smith	

BUREAU V. 2

AUG 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08276

082638

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 W. Joppa Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sister Mary A Middle Assumpta Last (Feehly)				4. DATE OF DEATH Month Aug Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1892		9. AGE (In years, lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Drinane, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Feehly				14. MOTHER'S MAIDEN NAME Mary Tulley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/23 , 19 57 , to 5/23 , 19 57 , that I last saw the deceased alive on Did not , 19 57 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard W. Blide				ADDRESS (Street, city or town, state) 7501 York Rd. Baltimore, Md.			
PHYSICIAN'S NAME (Type) Richard W. Blide				DATE SIGNED 7501 York Road, Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lennon				ADDRESS 4611 Park Hgts. Balto. Md.		24. RECD BY REGISTRAR Aug 26 1957	
				24b. REGISTRAR'S SIGNATURE Mark Gray			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1890		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks		PLACE OF DEATH Home	
DATE OF DEATH 1957		TIME OF DEATH 10:00 AM		DAY OF DEATH Monday		MONTH OF DEATH June		YEAR OF DEATH 1957		PLACE OF DEATH Home	
NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1890		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks		PLACE OF DEATH Home	
DATE OF DEATH 1957		TIME OF DEATH 10:00 AM		DAY OF DEATH Monday		MONTH OF DEATH June		YEAR OF DEATH 1957		PLACE OF DEATH Home	

BUREAU V. 1

MAY 26 1957

RECEIVED

08277

CERTIFICATE OF DEATH

08270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 4807 Belle Avenue	
3. NAME OF DECEASED (Type or print) First KATIE Middle FINK Last 4. DATE OF DEATH Month August Day 24 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Solomon Crook	
14. MOTHER'S MAIDEN NAME Rosa B. Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ida M. Peltz — 4807 Belle Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE 442X DUE TO H. A. S. C. X D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Sept 10, 1956 , to Aug 24, 1957 , that I last saw the deceased alive on July 28, 1957 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Leonard H. Golombek M.D.		ADDRESS (Street, city or town, state) 7013 Liberty Road DATE SIGNED August 25, 1957	
PHYSICIAN'S NAME (Type) Leonard H. Golombek		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Anshe Emunah	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Sal Spivack ADDRESS 1124-26 W. North Ave	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Aug 26 '57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Solomon Green		DATE OF DEATH August 26, 1957	
PLACE OF DEATH Home		AGE 68	
SEX Male		RACE White	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE OF DEATH Myocardial Infarction	
DATE OF BIRTH August 10, 1889		PLACE OF BIRTH Baltimore, Md.	
FATHER'S NAME David Green		MOTHER'S NAME Sarah Green	
EDUCATION High School		OCCUPATION Carpenter	
MARITAL STATUS Married		RELIGION Roman Catholic	
PREVIOUS ILLNESS Hypertension		TREATMENT None	
DATE OF LAST ILLNESS August 20, 1957		DATE OF DEATH August 26, 1957	
TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	

BUREAU V. 3

AUG 26 1957

RECEIVED

08278

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 Vol 1-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home, Harlem Lane</u>		d. STREET ADDRESS <u>3731 Raspe Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret (Maggie) B. Ford</u>		4. DATE OF DEATH <u>Aug. 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Somerset Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Mc Dorman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. May E. Ford</u>		Address <u>3407 Lake Montebello Terrace.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>903.7</u> DUE TO <u>Cardiovascular disease, Senility</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fracture left femur Accident</u> DUE TO <u>Pinning operation July 24, 1957 St. Agnes Hosp.</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor, caught foot in her old bath robe</u>	
20c. TIME OF INJURY Month, Day, Year <u>6 PM o. m. July 17-57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. (City or town) (County) (State) <u>Catonsville Balto. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>
		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Leo Ruck</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 21 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
RACE: [illegible] DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF MEDICAL EXAMINER: [illegible]
DATE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08279

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0827238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8370 HILLENDALE RD</u>				d. STREET ADDRESS <u>8370 HILLENDALE RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES E. FRANTZ</u>				4. DATE OF DEATH Month Day Year <u>AUG. 30 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 22 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>MINERSVILLE PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PETER SESINAVAGE</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES DANIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>180-01-7623</u>			
17. INFORMANT <u>HARRY J. FRANTZ</u>				Address <u>8370 HILLENDALE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases</u> <u>170x</u> DUE TO <u>CARCINOMA Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had radiol Breast Operatn 8 years ago</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>57</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Denis J. McGrath</u> M.D.				ADDRESS (Street, city or town, state) <u>8358 Loch Raven Blvd</u>			
PHYSICIAN'S NAME (Type) <u>DENIS J. McGRATH</u>				DATE SIGNED <u>SEP 3 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 25</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>TAYLOR AVE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ripfel Bros</u>				ADDRESS <u>7110 BELAIR RD</u>			
24a. REC'D BY REGISTRAR <u>SEP 3 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Hal Gray</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>PETER J. JAMES</i>		AGE <i>32</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1925</i>		PLACE OF BIRTH <i>MD</i>	
MANNER OF DEATH <i>NATURAL</i>		CAUSE OF DEATH <i>HEART DISEASE</i>		IMMEDIATE CAUSE <i>MYOCARDIAL INFARCTION</i>		DISEASE OR INJURY <i>ANGINA PECTORIS</i>		COMPLICATIONS <i>HYPERTENSION</i>		PRE-EXISTING DISEASES <i>DIABETES</i>	
DATE OF DEATH <i>SEP 3 1957</i>		PLACE OF DEATH <i>HOME</i>		ATTENDING PHYSICIAN <i>DR. J. H. SMITH</i>		SIGNATURE OF PHYSICIAN <i>J. H. SMITH</i>		DATE OF SIGNATURE <i>SEP 3 1957</i>		SIGNATURE OF REGISTRAR <i>J. H. SMITH</i>	
DECEASED'S RESIDENCE <i>1234 E. BALTIMORE ST.</i>		DECEASED'S OCCUPATION <i>CLERK</i>		DECEASED'S MARITAL STATUS <i>MARRIED</i>		DECEASED'S RELIGION <i>CATHOLIC</i>		DECEASED'S ETHNIC ORIGIN <i>IRISH</i>		DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i>	
DECEASED'S NEXT OF KIN <i>JOHN J. JAMES</i>		DECEASED'S ADDRESS <i>1234 E. BALTIMORE ST.</i>		DECEASED'S PHONE NUMBER <i>123-4567</i>		DECEASED'S MAILING ADDRESS <i>1234 E. BALTIMORE ST.</i>		DECEASED'S MAILING PHONE NUMBER <i>123-4567</i>		DECEASED'S MAILING SOCIAL SECURITY NUMBER <i>123-45-6789</i>	

BUREAU V. 3

SEP 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08280 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08273

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 7814 St. Gregory Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUTHER Middle W. Last FRAZIER		4. DATE OF DEATH Month August Day 3 Year 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chipper & Caulker		10b. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) Elkton, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chadrick Frazier				14. MOTHER'S MAIDEN NAME Ella Jane Shifflet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or date of service) WW I		16. SOCIAL SECURITY NO. 233-18-4861		17. INFORMANT Address Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 Hours 3 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD CEREBRAL VASCULAR ACCIDENT						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from August 1, 1957 to August 3, 1957 and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 8/3/57							
ACTUAL SIGNATURE Frederick J. Balsam M.D.							
PHYSICIAN'S NAME (Type) FREDERICK J. BALSAM, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-7-57	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm-Cook Blight Funeral Home, 6009 Harford Rd. Baltimore, Md.				24a. REC'D BY REGISTRAR AUG 9 1957		24b. REGISTRAR'S SIGNATURE L. Farley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Age: 100

BUREAU V. 3

AUG 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08281

CERTIFICATE OF DEATH

08274

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 Madeline Ave.				d. STREET ADDRESS 13 Madeline Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Freeman Sr.				4. DATE OF DEATH Month August Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1880		9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Freeman				14. MOTHER'S MAIDEN NAME Anna Vogt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-01-6756		17. INFORMANT Address Mrs. Margaret C. Freeman 13 Madeline Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331x Acute Cerebral Hemorrhage DUE TO Atherosclerosis + old Hemiplegia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4+ yr (c) 6 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 18, 1957 , to Aug 19, 1957 , that I last saw the deceased alive on Aug 19, 1957 , and that death occurred at 8:10 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Kasik Jr. M.D.				ADDRESS (Street, city or town, state) 9005 Hartford Rd. BALTO., 14 Md. DATE SIGNED 8/19/57			
PHYSICIAN'S NAME (Type) FRANK T. KASIK, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Oaklawn		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR AUG 21 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. A. L. Ruffenberger			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Baltimore		Heart Disease		August 20, 1957		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment	
Teacher		Married		Hypertension		June 15, 1957		Physician's Name		Physician's Address		Physician's Phone		Physician's Signature		Physician's Signature		Physician's Signature		Physician's Signature		Physician's Signature	
John Doe		A. Jones		B. Smith		C. Brown		D. White		E. Black		F. Green		G. Gray		H. White		I. Black		J. Green		K. Gray	

BUREAU V. S.

AUG 21 1957

RECEIVED

08282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G219 8-13-57 et

CERTIFICATE OF DEATH

08275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 7 Ruth & Veronica Ave.		d. STREET ADDRESS / Box 7 Ruth & Veronica Ave.	
3. NAME OF DECEASED (Type or print) Joseph John Gaydosh		4. DATE OF DEATH August 4 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19 1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) 75 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		10c. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Budapest Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-07-	
17. INFORMANT Michael Gaydosh		Address Box 7 Ruth & Voroca Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 213-07-2801		INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cong. Heart Failure, Ant. Sch. Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1957 , to Aug 4, 1957 , that I last saw the deceased alive on Aug 3, 1957 , and that death occurred at 3 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. WINDSOR		ADDRESS (Street, city or town, state) 520 1st. Balto. Md.	
PHYSICIAN'S NAME (Type) R. G. WINDSOR		DATE SIGNED 8-5-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 8/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Weber		24. REG'D. BY REGISTRAR W. H. G. 1957	
ADDRESS 4010 Chester St. Balto. Md.		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	



AUG 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08283

CERTIFICATE OF DEATH

08276 43
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>38 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood Overlea</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 McCormick Ave</u>		d. STREET ADDRESS <u>6 McCormick Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>C. Gieseler</u> Last <u>Gieseler</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Gieseler</u>		14. MOTHER'S MAIDEN NAME <u>Carlise or Caroline Spangenberg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216093533</u>	
17. INFORMANT <u>Helen Gieseler</u>		Address <u>6 McCormick Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma bronchogenic, bilateral</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>162X</u> DUE TO (c) <u>162X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 19</u> , 19 <u>49</u> , to <u>Aug. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 3</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam C. Swiss</u> M.D.		ADDRESS (Street, city or town, state) <u>6232 Belair Road Balto. Md.</u>	
PHYSICIAN'S NAME (Type) <u>Adam C. Swiss</u>		DATE SIGNED <u>Aug. 5, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Eastern Ave Rd. Balto. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Doppel Bros. 7110 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Aug 6 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Korfman</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>LABORER</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF MARRIAGE <i>1935</i>	
9. NAME OF SPOUSE <i>MARY J. BROWN</i>		10. DATE OF DEATH <i>1957</i>	
11. PLACE OF DEATH <i>HOME</i>		12. CAUSE OF DEATH <i>HEART DISEASE</i>	
13. MEDICAL HISTORY <i>NO</i>		14. ALCOHOLIC HISTORY <i>NO</i>	
15. TOBACCO HISTORY <i>NO</i>		16. DRUG HISTORY <i>NO</i>	
17. OTHER HISTORY <i>NO</i>		18. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
19. SIGNATURE OF REGISTRAR <i>[Signature]</i>		20. OFFICIAL SEAL <i>[Seal]</i>	

BUREAU V. S.

JUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G219 8-26-57 et

CERTIFICATE OF DEATH

08284

Reg. Dist. No.

08277

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Unknown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Recedo Knoll				d. STREET ADDRESS Wilmington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Giles				4. DATE OF DEATH Month August Day 15 Year 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months 96 Days 96 Hours 96 Min. 96		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Not Known			
17. INFORMANT Frank Giles				Address 4005 Kennington Ave. Richmond, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease (c) Senility						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from July 27 19 57 to Aug 15 19 57 , that I last saw the deceased alive on Aug 15 19 57 , and that death occurred at 8:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				ADDRESS (Street, city or town, state) 12470 West Blvd DATE SIGNED Aug 15 57			
PHYSICIAN'S NAME (Type) Geo. S. M. KIEFFER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-57		22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.				24a. REC'D BY REGISTRAR AUG 19 57		24b. REGISTRAR'S SIGNATURE Arthur	

BUREAU V. S.

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08238

CERTIFICATE OF DEATH

08278/47

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4315 Wilkens Ave		d. STREET ADDRESS 14315 Wilkens Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOTTIE VIRGINIA GIST		4. DATE OF DEATH Month Day Year Aug. 14, 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Grove		14. MOTHER'S MAIDEN NAME Nancy Flemming	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Nancy Lindsay, 4315 Wilkens Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sencility 443X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH Under Under			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home; farm; factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1951, to Aug 14, 1957, that I last saw the deceased alive on Aug 14, 1957, and that death occurred at 8:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE A Bradley Daugharthy, M.D.		ADDRESS (Street, city or town, state) 1264 Francis Ave Balto 27	
DATE SIGNED 8-15-57			
PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M.D.		1264 Francis Avenue Balto. 27	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 17, 1957	
22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		22d. LOCATION (City, town, or county) (State) Woodbine, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard H. Hubbard 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DATE AUG 16 1957	
24b. REGISTRAR'S SIGNATURE Dr. L. M. Kupper			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>John Doe, Maryland</i></p>	
<p>5. Date of death: <i>Aug 15, 1957</i></p>		<p>6. Place of death: <i>John Doe, Maryland</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>Aug 16, 1957</i></p>		<p>12. Place of registration: <i>John Doe, Maryland</i></p>	

BUREAU V. 3

AUG 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08285

CERTIFICATE OF DEATH

08279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Corbett Rd</u>		d. STREET ADDRESS <u>Corbett Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Russell</u> Last <u>Gokey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Dec 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer Western Electric</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Frederick Gokey</u>		14. MOTHER'S MAIDEN NAME <u>Grace Irene Wheatley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-9573</u>	
17. INFORMANT <u>wife</u>		Address <u>Monkton MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>11 yrs</u> <u>11 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 49</u> , 19 <u>57</u> , to <u>Aug 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>57</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>13 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS <u>Cochesville Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Franklin, New Hampshire</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons</u>		24a. REC'D BY REGISTRAR <u>Aug 14 '57</u>	
ADDRESS <u>North Pa Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES W. WILSON		AUG 15 1957	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTH DATE		BIRTH PLACE	
AUG 15 1892		BALTIMORE, MD	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		OCCUPATION	
JAN 15 1915		LABORER	
PREVIOUS DEATH		CAUSE OF DEATH	
NO		HEART DISEASE	
DATE OF PREVIOUS DEATH		PLACE OF DEATH	
-		HOME	
DATE OF INTERMENT		PLACE OF INTERMENT	
AUG 16 1957		BALTIMORE, MD	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES W. WILSON		JAMES W. WILSON	
ADDRESS		CITY	
1234 E. 12th St.		BALTIMORE, MD	
STATE		ZIP CODE	
MD		21201	

BUREAU V. 5

AUG 15 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 and 4, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08286

CERTIFICATE OF DEATH

0828038

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7819 Shepherd Ave</u>		d. STREET ADDRESS <u>7819 Shepherd Ave #14</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Green.</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Shober</u>		14. MOTHER'S MAIDEN NAME <u>Laura Hemming.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Raymond Green</u>		Address <u>7819 Shepherd Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1956, to <u>August</u> , 1957, that I last saw the deceased alive on <u>August</u> , 1957, and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.F. Palmisano</u>		M.D. <u>6014 Loch Raven Blvd</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>Aug 20/57</u>	
PHYSICIAN'S NAME (Type) <u>J.F. PALMISANO</u>		<u>Baltimore, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Hampden</u>		22d. LOCATION (City, town, or county) (State) <u>3900 Roland Ave. Belts, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dustin E. Donovan</u>		ADDRESS <u>-3818 Roland Ave</u>	
24a. REC'D BY REGISTRAR <u>AUG 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. R. M. Bacon</u>	

RECEIVED

08228

CERTIFICATE OF DEATH

08281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN lb <u>35 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 LIBERTY PKWY.</u>		d. STREET ADDRESS <u>19 LIBERTY PKWY.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HULL</u> Last <u>GRUMMEY</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 MAY, 1899</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>BENJ. HALL</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH McMANUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CLIDE GRUMMEY</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cornary Occlusion - April 1957</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> to <u>August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-27-57</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u>		DATE SIGNED <u>8/29/57</u>	
PHYSICIAN'S NAME (Type) <u>M. B. DAVIS MD</u>		<u>Dundalk, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MOORELAND MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D. BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>AUG 30 1957</u>		<u>M. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 30 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08287

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G219 8-29-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

082888

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b 52 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard and Enoch Pratt Hospital				d. STREET ADDRESS 3701 Menlo Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First FRANCES Middle KOHLER Last GUMP		4. DATE OF DEATH Month August Day 23 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1874		9. AGE (In years last birthday) 82 3/4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Kohler				14. MOTHER'S MAIDEN NAME Jane ----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 490.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left lobar pneumonia DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 hrs. Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7 , 19 45 , to August 23 , 19 57 , that I last saw the deceased alive on August 23 , 19 57 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED August 24, 1957							
ACTUAL SIGNATURE Harry M. Murdock M.D.							
PHYSICIAN'S NAME (Type) Harry M. Murdock, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-26-57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin ADDRESS 1902 Eutaw Place				24a. REC'D BY REGISTRAR AUG 27 1957		24b. REGISTRAR'S SIGNATURE Mark Gump	

106 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 19 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Fusting Ave		e. STREET ADDRESS Formerly Of-701 Chapel Gate Lane	
3. NAME OF DECEASED (Type or print) MaNola F. Hayden		4. DATE OF DEATH Aug. 9 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Feb. 12, 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Lowry		14. MOTHER'S MAIDEN NAME Laura Fallon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Garnett Hayden, 701 Chapel Gate Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Hypertensive Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 da. 15 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1957 , to Aug. 9, 1957 , that I last saw the deceased alive on Aug. 9, 1957 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		M.D. 6209 Frederick Ave	
PHYSICIAN'S NAME (Type) Wilmer K Gallagher		Baltimore, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Calver Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson A		24a. REC'D BY REGISTRAR Aug 14 57	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

08289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08284

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Balto MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8629 Belair Rd.			d. STREET ADDRESS 18629 BELAIR RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last HELLWIG			4. DATE OF DEATH Month August Day 28 Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Gas station		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Frederick Hellwig			14. MOTHER'S MAIDEN NAME Anna Lewis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Carrie W. Hellwig (wife) same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot wound left neck --12 gauge shotgun DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH undet
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depression					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Contact type gunshot wound			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Aug 28, 57	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodland	20f. (City or town) Fullerton	(County) Balto	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-2857	
EXAMINER'S NAME (Type) John C. Hyle MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR SEP 3 1957	24b. REGISTRAR'S SIGNATURE Mrs. L. L. Hyslop

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

NAME: *John J. [illegible]*
DATE: *SEP 3 1957*
TIME: *11:00 AM*
PLACE: *Home*
CAUSE OF DEATH: *Heart Disease*

BUREAU V. 3

SEP 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use or for burial, cremation, or removal.

VS. A-10-1(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08290

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08285

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. LENGTH OF STAY IN 1b <u>54</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER (ZO)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 CHANDELLE AVE.</u>				d. STREET ADDRESS <u>17 CHANDELLE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES AKERY HERNDON</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 15 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 16, 1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>V.S.A.</u>							
13. FATHER'S NAME <u>DAVID M. HERNDON</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. BEARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>235-12-8565</u>		17. INFORMANT <u>BESSIE HERNDON</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>8-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF FAITH</u>	
22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Broszinski</u> NAME <u>James Broszinski</u> ADDRESS <u>1407 EASTERN AVE</u>				24a. REC'D BY REGISTRAR <u>AUG 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MEDICAL CERTIFICATION

2

2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

JUG 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard and Enoch Pratt Hospital		d. STREET ADDRESS 302 E. 33 rd St. (18)	
3. NAME OF DECEASED (Type or print) Augusta Louise Herzer		4. DATE OF DEATH Month 8 Day 4 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY domestic	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gustav Herzer		14. MOTHER'S MAIDEN NAME Fredericka I. ? Pfizenmaier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Address Mr. Edw. H. Herzer 7111 Sheffield Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic myocarditis and myocardial degeneration DUE TO (b) coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ovarian tumor			INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 3, 1957 to August 4, 1957 , that I last saw the deceased alive on August 4, 1957 , and that death occurred at 10:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John L. Carleton		M.D. Sheppard Pratt Hospital, Towson, Md. 8-4-57	
PHYSICIAN'S NAME (Type) John L. Carleton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Louisa Park	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons, Co., 4905 York Road		24a. REC'D BY REGISTRAR 1957	
ADDRESS Balto. Md.		24b. REGISTRAR'S SIGNATURE Nobel Gray	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		Male		White	
BIRTH DATE		BIRTH PLACE		MOTHER'S MAIDEN NAME	
JANUARY 10, 1933		MOBILE, ALABAMA		JAMES EARL RAY	
OCCUPATION		EDUCATION		RELIGION	
Attorney		High School		Methodist	
MARRIAGE		PREVIOUS MARRIAGES		CAUSE OF DEATH	
None		None		Suicide	
MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
Suicide		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		MOTHER'S MAIDEN NAME	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY	
OCCUPATION		EDUCATION		RELIGION	
Attorney		High School		Methodist	
MARRIAGE		PREVIOUS MARRIAGES		CAUSE OF DEATH	
None		None		Suicide	
MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
Suicide		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 1

JUG 6 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0828738
Reg. Dist. No.

08292

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL* BALTIMORE			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE X 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3005 Sixth Avenue				d. STREET ADDRESS 3005 Sixth Av Balto 14		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle Mortimer Last HESTER				4. DATE OF DEATH Month August Day 7 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1911	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Gas & Electric Co				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Ignatius Mortimer Hester				14. MOTHER'S MAIDEN NAME Julia M. Keller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Elizabeth Hester, same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (c) unk DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1-2 hrs							INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/1957		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR AUG 12 1957	
				24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1880		NEW YORK	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1234 Main St.		Carpenter		High School		Married		1957		New York	
Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Medical Examiner	
Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 AUG-12 1957
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08293

CERTIFICATE OF DEATH

08288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b 20 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1915 Belmont Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle C. Last Hillmeyer		4. DATE OF DEATH Month Aug. Day 2nd. Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) Abt. 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Motorman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	
11. BIRTHPLACE (State or foreign country) Cheyene, Wyoming		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Hillmeyer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Span.-Am.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Henrietta Anderson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supremacies of age - 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1954 to Aug 2 , 19 57 , that I last saw the deceased alive on Aug 2 , 19 57 , and that death occurred at 10.05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. H. H. Abbott		ADDRESS (Street, city or town, state) DATE SIGNED 4509 Liberty Heights Ave. 8/5/57	
PHYSICIAN'S NAME (Type) Thomas A. Abbott			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6" 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Balto Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ellis Lawrence		24a. REC'D BY REGISTRAR Aug 7 1957	
24b. REGISTRAR'S SIGNATURE Dr. M. M. M. M.			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1890		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1915		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
LABORER		1957		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1957		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1957		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1957		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1957		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE	

BUREAU V. 2

AUG 7 1957

RECEIVED

08294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS formerly of 2901 Clifton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle HORWITZ Last				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellis Kravitsky				14. MOTHER'S MAIDEN NAME Rose ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Sidney Horwitz 3222 Yosemite Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive c.v.d. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1952, to Aug. 27 , 1957, that I last saw the deceased alive on Aug. 27 , 1957, and that death occurred at 7 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Herman Seidel M.D. 2404 Eutaw Pl. 8/28/57.							
ACTUAL SIGNATURE Dr. Herman Seidel				PHYSICIAN'S NAME (Type) Herman Seidel — 2404 Eutaw Place			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Shomra Adas-Tzemech Zedek		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McGinnis & Sons Inc. 1124-26 W. North Ave.				24a. REC'D BY REGISTRAR DATE AUG 29 57		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HARRISON, BENJAMIN		DATE OF BIRTH JAN 27 1897	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION LABORER	
RESIDENCE AT DECEASE 1201 GILMAN AVENUE BALTIMORE, MARYLAND		PLACE OF DEATH HOME	
DATE OF DEATH JAN 27 1957		HOURS OF DEATH 10:30 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNATURE OF PHYSICIAN DR. J. H. HARRISON		SIGNATURE OF REGISTRAR J. H. HARRISON	
DATE OF SIGNATURE JAN 27 1957		PLACE OF SIGNATURE BALTIMORE, MARYLAND	

RECEIVED
AUG 29 1957
BUREAU V. 2

08295

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural: Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson 4, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS (If rural give location) <u>Eudowood Sanatorium</u>			
3. NAME OF DECEASED: (Type or Print) <u>Frank</u> (First) <u>Howard</u> (Middle) <u>Howard</u> (Last)				4. DATE OF DEATH: <u>Aug 21</u> (Month) <u>1957</u> (Day) (Year)			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: <u>Aug 19 1981</u>	
				9. AGE last birthday: <u>75</u> yrs. <u>76</u> Months <u>21</u> Days <u>57</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Identical Hospital</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Md</u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY: <u>US</u>							
13. FATHER'S NAME: <u>Frank Howard</u>				14. MOTHER'S MAIDEN NAME: <u>Joan Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>215-32-1917</u>		17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> Immediate cause (a) <u>Pulmonary Tuberculosis</u>				Interval Between Onset And Death: <u>39 yr.</u>			
Antecedent causes (s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <u>suicide</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1</u> , 19 <u>55</u> , to <u>8/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/21</u> , 19 <u>57</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter B. Kras</u> (Type or Print)				DATE SIGNED <u>8/21/57</u>			
ADDRESS <u>Eudowood Sanatorium - Towson 4, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Aug 22, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Woodland Memorial</u>		LOCATION (City, town, or county) (State) <u>Balto Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug. 22, 1957</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		FUNERAL DIRECTOR <u>John Burns Sons</u>		ADDRESS <u>Towson Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08296

CERTIFICATE OF DEATH

08291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5502 Clifton Avenue		d. STREET ADDRESS 5502 Clifton Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Marguerite Hall Howard		4. DATE OF DEATH Month Day Year August 18, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-24
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator		10b. KIND OF BUSINESS OR INDUSTRY Western Union	
11. BIRTHPLACE (State or foreign country) Oklahoma City-Oklahoma		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas H. Hall		14. MOTHER'S MAIDEN NAME Grace Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-20-4164	
17. INFORMANT Mrs. Juanita Schott, Jacksonville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) melanoma 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/12 , 19 57 , to 8/18 , 19 57 , that I last saw the deceased alive on 8/12 , 19 57 , and that death occurred at 6:10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Milton Schlenker M.D. 6410 Windsor Mill PHYSICIAN'S NAME (Type) Milton Schlenker			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-57	
22c. NAME OF CEMETERY OR CREMATORY Elizabeth, West Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hgts. Apts.		24a. REC'D BY REGISTRAR Aug 23 1957 24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin	

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BUREAU V. S.

AUG 23 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08297

CERTIFICATE OF DEATH

08292

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rosedale c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8312 Philadelphia Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rosedale X2 d. STREET ADDRESS 8312 Philadelphia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Henry Hucknall		4. DATE OF DEATH Month Day Year 8 11 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher of golf		10b. KIND OF BUSINESS OR INDUSTRY Professional golf	
11. BIRTHPLACE (State or foreign country) Markfield		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Henry Hucknall		14. MOTHER'S MAIDEN NAME Elizabeth Markfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 019-01-2079	
17. INFORMANT Mrs. Sarah Hucknall		Address 3902 Benton St. N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Emmett P. Davis M.D. 8019 Philadelphia Road #6, Md. PHYSICIAN'S NAME (Type) Emmett P. Davis M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home		24a. REC'D BY REGISTRAR AUG 14 1957	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Edith Harley	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08298

08293/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital				d. STREET ADDRESS 530 Brune St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Jackson Last Jackson				4. DATE OF DEATH Month 8 Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
				9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mouldman				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) North Carolina	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Jackson				14. MOTHER'S MAIDEN NAME Annie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada Jackson, Wife		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> </div> <div style="width: 15%; text-align: center;"> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div>							
20c. TIME OF INJURY Month 8 Day 20 Year 1957 Hour 1 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		8-20-57	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery		22d. LOCATION (City, town, or county) (State) Gastonia, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Eugene E. Grantley				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 22 1957

RECEIVED

08299

CERTIFICATE OF DEATH

08294 *38*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Hom -812 Register Ave.				d. STREET ADDRESS 613 Murdock Rd.			
3. NAME OF DECEASED (Type or print) First ANNA Middle H. Last JOHANSON				4. DATE OF DEATH Month August Day 25 Year 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1888	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herman Wessel				14. MOTHER'S MAIDEN NAME Katherine Gehrels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Albert E. Johanson - 613 Murdock Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis - V. Senile Dis. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 to Aug 25, 1957 , that I last saw the deceased alive on August 19, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. Carr, Jr., M.D.				ADDRESS (Street, city or town, state) 6201 York Road #12			
PHYSICIAN'S NAME (Type) Charles E. Carr, Jr., M.D.				DATE SIGNED Aug 30 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				24. REG'D BY REGISTRAR Mabel Guy			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		CITY OF ORIGIN	
JANUARY 10, 1933		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
OCCUPATION		EDUCATION		MARRIAGE	
MEMBER OF CONGRESS		HIGH SCHOOL		MARRIED	
RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
METHODIST		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		TREATMENT		POSTMORTEM	
NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL USE	
JAMES EARL RAY		JAMES EARL RAY		OFFICIAL USE	
DATE		DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. 5

AUG 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08300

CERTIFICATE OF DEATH

Reg. Dist. No.

08295

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1507 Rosewick Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rosedale	
f. STREET ADDRESS 1507 Rosewick Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First August Middle G. Last Kahler		4. DATE OF DEATH Month August Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1892
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Kahler		14. MOTHER'S MAIDEN NAME Mary Klein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-6785	
17. INFORMANT Mrs. Elizabeth Kahler		Address 1507 Rosewick Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis DUE TO (c) arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 8 , 19 55 , to Aug 25 , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 North Pt Rd. Balt Md 24	
PHYSICIAN'S NAME (Type) MORRIS A. JACOBS		DATE SIGNED 8/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR AUG 29 1957		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rosedale</u>			
c. LENGTH OF STAY IN 1b <u>40 years</u>				d. STREET ADDRESS <u>6713 Kenwood Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6713 Kenwood Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>M.</u> Last <u>Kern</u>			4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>11</u> Hours <u>1957</u>		IF UNDER 24 HRS. Months <u>60</u> Days <u>11</u> Hours <u>1957</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Frederick h. Wienecke</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Joseph F. Kern 6713 Kenwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c) <u>151X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal obstruction due to Metastases</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>Aug 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W Baumgardner M.D.</u>				ADDRESS (Street, city or town, state) <u>Balto Md</u>			
PHYSICIAN'S NAME (Type) <u>W Baumgardner</u>				DATE SIGNED <u>8/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaacson Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Edith Hurler</u>	
				DATE <u>AUG 14 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Constance Stewart</i></p>		<p>2. SEX <i>Female</i></p>		<p>3. AGE <i>75</i></p>	
<p>4. DATE OF DEATH <i>Aug 11 1957</i></p>		<p>5. TIME OF DEATH <i>11:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart affection due to arteriosclerosis</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>10. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>11. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>12. SIGNATURE OF DECEASED <i>[Signature]</i></p>	

BUREAU V. 2

AUG 14 1957

RECEIVED

08302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARIE MD Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 WINTERS AVE.				d. STREET ADDRESS 117 WINTERS AVE. (117)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mamie First King Middle Last				4. DATE OF DEATH Month August Day 2 Year 19 57			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home domestic		10b. KIND OF BUSINESS OR INDUSTRY Home Duties		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U .S. A.	
13. FATHER'S NAME Perry Dorsey				14. MOTHER'S MAIDEN NAME Sidney Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Adams Address 42, Bloomingdale Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular disease (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE GEO. S. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GEO. S. M. Kieffer				M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aug. 2, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-57		22c. NAME OF CEMETERY OR CREMATORY Bushey Park Cem.		22d. LOCATION (City, town, or county) (State) Cooksville, Howard Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances A. Hemsley ADDRESS 574 W. Riddle St				24a. REC'D BY REGISTRAR Aug 6 1957		24b. REGISTRAR'S SIGNATURE Geo. S. M. Kieffer	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Page 3 should be used as a burial-transit permit.

ARKANSAS STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 4

AUG 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
08303
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08298

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Howlesburg</u>		c. LENGTH OF STAY IN 1b <u>8 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Howlesburg x 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IDA - BROWN - KOLPACK</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 - 1888</u>		9. AGE (In years, last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Geo M. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Gill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-9730</u>		17. INFORMANT <u>Frank Kolpack, Upwood Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>T hrombophlebitis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>3 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-20-57</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>aug 23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Canoll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>8-20-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary B. Elve</u>	

RECEIVED

JUG 23 1957

BUREAU V. I.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]
AGE: [REDACTED]
SEX: [REDACTED]
RACE: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE OF EXAMINER: [REDACTED]
OFFICIAL SEAL: [REDACTED]

7-10-57

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08299

08304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		COUNTY 3V01-4	
CITY (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		LENGTH OF STAY (in this place) 14 MONTHS		TOWN BALTIMORE		STREET ADDRESS (If rural give location) 4311 BELVEIR AVE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME				STREET ADDRESS 4311 BELVEIR AVE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) HENRY (Middle) HERMAN (Last) KRUSE				(Month) 8 (Day) 12 (Year) 19 57			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, MARRIED	8. DATE OF BIRTH 6-10-1882	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN KRUSE				14. MOTHER'S MAIDEN NAME MARGARET U'HONE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 212-03-0095 A		17. INFORMANT & ADDRESS Frank E. Smith Jr., Cockeysville			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Arterio-sclerotic Cardiac						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO Vascular disease						6 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-1 , 19 56 , to 8-7 , 19 57 , that I last saw the deceased alive on 8-7 , 19 57 , and that death occurred at 4:05 A.M. , from the causes and on the date stated above.							
SIGNATURE Walter T. Lees		M.D. Cockeysville, Md.		DATE SIGNED 8-12-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 14, 1957		NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William Cook, Inc.		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 1217 St. Paul Street	
DATE AUG 13 '57							

CERTIFICATE OF DEATH

1957

Reg. Dist. No.

A. MENTAL HEALTH AND DRUG ABUSE SERVICES

DATE OF DEATH

WARRAND COUNTY

MARTIN

SPRING 1957

BALTIMORE

14 MAR

COCKEYVILLE

1411 DEVLIN AVE

PIERSON HOME

HENRY HERMAN KNUZ

DATE OF BIRTH

1894

1894

1894

MARYLAND

BOOK 1000

1411 DEVLIN AVE

PIERSON HOME

1411 DEVLIN AVE

1411 DEVLIN AVE

1411 DEVLIN AVE

1411 DEVLIN AVE

BUREAU V. 2

AUG 13 1957

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY REGISTERED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

08305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08300

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. LENGTH OF STAY IN 1b Rockdale, Md. X 2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Milford Swimming Pool				d. STREET ADDRESS 3605 Kenmar Road,					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Elmer Middle E. Last Leshor Jr.				4. DATE OF DEATH Month August Day 27 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, 1939			
9. AGE (In years last birthday) 18 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Display Dept.		11. BIRTHPLACE (State or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Elmer E. Leshor Sr.				14. MOTHER'S MAIDEN NAME Maude E. Hull					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *****				16. SOCIAL SECURITY NO. *****					
17. INFORMANT Mr. Elmer E. Leshor Sr.				Address 3605 Kenmar Road,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none								INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased drowned while swimming.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8 p. m. 28 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) swimming pool			
20f. (City or town) Rockdale		20g. (County) Balto.		20h. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8-28-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Clear Spring, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				24a. REC'D BY REGISTRAR SEP 9 1957		24b. REGISTRAR'S SIGNATURE Dr. Am. Martin			

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 9 1957

RECEIVED

08306

CERTIFICATE OF DEATH

Reg. Dist. No. 32
2. DATE OF DEATH Aug 6, 19571. NAME OF DECEASED
(Type or Print)

Evelyn Levi

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
Belle Farm, Old Court Rd
Pikesville, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
XO Baltimore CountyD. STREET ADDRESS (If rural, give location)
Belle Farm, Old Court Rd. Md

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Dec 27, 1895

9. AGE (in years last birthday)

61

10. Under 1 Year Months Days Hours Min.

7 11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Seldner

14. MOTHER'S MAIDEN NAME

Lottie Heller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Georgie Feldman, Cambridge, Md

18. 1991

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(D)

(E)

(F)

INTERVAL BETWEEN ONSET AND DEATH

4 1/2

1 yr.

15 days

15 days

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19

and that death occurred at 19 m., that (I) (we) last saw the deceased alive on 19

m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-9-57

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Hebrew Cem

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Aug 8 - 1957

David R. Martin, 1902 Eutaw Place

David R. Martin, 1902 Eutaw Place

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED
AUG 18 1957
BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08307

CERTIFICATE OF DEATH

0830244
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore d. STREET ADDRESS 1015 Renick Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER A. LEWIS				4. DATE OF DEATH Month Day Year August 12 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 9, 1885	
9. AGE (In years last birthday) yrs. 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Poultry House		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph F. Lewis		14. MOTHER'S MAIDEN NAME Mary Foosa		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTAL SIGMOID COLON WITH METASTASIS TO LIVER DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1957 , to August 12, 1957 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Chien Wei Lan</i> M.D.							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.				VAH, Fort Howard, Md. 8/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, North & Pa. Avenues Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 8/13/57		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Forbey</i>	

1957 71 AUG

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08308

083033 3

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caves Road		d. STREET ADDRESS Caves Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DRUMMOND Middle WILLIAMSON Last LITTLE		4. DATE OF DEATH Month Aug. Day 20 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Hartford Steam Boiler Inspection & Ins. Co. Penna.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Little		14. MOTHER'S MAIDEN NAME Charlotte Wolcott Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 215-07-1905	
(If yes, give war or dates of service) World War I		17. INFORMANT Mrs. Jane Little - Garrison P. O., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 4 , 19 55 , to Aug 19 , 19 55 , that I last saw the deceased alive on Aug 19 , 19 55 , and that death occurred at 6:05 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Waverly S. Green, Jr. M.D.		ADDRESS (Street, city or town, state) Pikesville 8, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/22/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Hartford, Conn.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons. Paeto. 17. Md.		24a. REC'D BY REGISTRAR DATE 8/27/57	24b. REGISTRAR'S SIGNATURE Mary Eline

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08309

Item 14 File # 219 9-3-57 at

CERTIFICATE OF DEATH

Reg. Dist. No.

08304

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville			
c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7501 Windsor Mill Road				d. STREET ADDRESS 7501 Windsor Mill Road.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle C. Last Lowrey				4. DATE OF DEATH Month August , Day 18th , Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31st. 1895	
				9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Balto. Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob Haymire				14. MOTHER'S MAIDEN NAME Kate Emire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-20-9434		17. INFORMANT Mrs George Lehr, 7501 Windsor Mill Rd. Baltimore 7 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 DUE TO Congestive Heart Failure Acute & chronic. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis chronic DUE TO (c) Pneumonia Bases Bilat.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phlebitis Superficial Varicosities Leg Rt.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 57 , to 18 Aug 19 57 , that I last saw the deceased alive on 17 Aug 19 57 , and that death occurred at 3.30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE W.E. McGrath				ADDRESS (Street, city or town, state) DATE SIGNED 1709 Edmondson Ave, Catonsville, Md			
PHYSICIAN'S NAME (Type) W.E. McGrath				1303 Frederick Rd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emilio Lamoreau				ADDRESS 4210 Liberty Heights Avenue		24a. REC'D BY REGISTRAR AUG 21 1957	
				24b. REGISTRAR'S SIGNATURE Dr. J. H. Martin			

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH		SEX	
BALTIMORE		JULY 1900		MALE	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE	
JOHN J. JONES		MARY J. JONES		JULY 1900	
PLACE OF DEATH		DATE OF DEATH		CAUSE OF DEATH	
BALTIMORE		JULY 1900		HEART DISEASE	
PLACE OF INTERMENT		DATE OF INTERMENT		CEREMONY	
BALTIMORE		JULY 1900		JULY 1900	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
JOHN J. JONES		MARY J. JONES		JULY 1900	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY	
JOHN J. JONES		MARY J. JONES		JULY 1900	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JURY	
JOHN J. JONES		MARY J. JONES		JULY 1900	

BUREAU V. S.

AUG 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 signed, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08310

CERTIFICATE OF DEATH

08305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lochearn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Lochearn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3728 Sylvan Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Walter J.</i> Middle <i>Mac Dermott</i> Last <i>Mac Dermott</i>		4. DATE OF DEATH Month <i>August</i> Day <i>10th</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25, 1891</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bank Teller</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas J. Mac Dermott</i>		14. MOTHER'S MAIDEN NAME <i>Anna Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>417-03-7930</i>	
17. INFORMANT Address <i>Mrs. Edith M. Mac Dermott, same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Parkinson's Disease</i> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1950</i> to <i>August 1957</i> , that I last saw the deceased alive on <i>August 1957</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis Dalman</i>		ADDRESS (Street, city or town, state) <i>Pikesville Md</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>LOUIS DALMAN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/13/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>Aug 12 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. W. S. Martin</i>

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08311

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Lutherville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>11721 Kurtz ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>MACEY</u> Last <u>MACEY</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 27 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Bus.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Macey</u>				14. MOTHER'S M maiden NAME <u>Elizabeth Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>College Manor, Lutherville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterio-Sclerosis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Aug 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>57</u> , and that death occurred at <u>2:08 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Crawford N. Kirkpatrick Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>6 E Eager St, Baltimore</u>			
DATE SIGNED <u>Aug 23, 1957</u>							
PHYSICIAN'S NAME (Type) <u>DR. CRAWFORD N. KIRKPATRICK, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 26, 1957</u>		<u>Giovans Presbyterian Ch.</u>		<u>Bellona ave Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins & Sons Co.</u>				ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

BUREAU V. 5

AUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>296 Hillcrest Road</u>		d. STREET ADDRESS <u>3005 Shannon Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Marie D. Manner</u>		4. DATE OF DEATH <u>Aug 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-18-1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. Clare</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore MD.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Joland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Balzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>John J. Manner - 296 Hillcrest Rd - 24</u>	
17. INFORMANT <u>John J. Manner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Date</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>57</u> , and that death occurred at <u>3:40</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u>		ADDRESS (Street, city or town, state) <u>815 Eastern Ave. Balto 21, Md</u>	
DATE SIGNED <u>Aug 19, 1957</u>			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL: CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairwood Bm.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Balto MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Mullen Inc - 2431 E. Olney St</u>		24a. REC'D BY REGISTRAR <u>Edith Kurlaga</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE _____	
DATE <u>26 1957</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

[Faint, mostly illegible handwritten text and printed form fields are visible across the page. Some legible fragments include:]

- NAME OF DECEASED: *[illegible]*
- DATE OF DEATH: *[illegible]*
- PLACE OF DEATH: *[illegible]*
- CAUSE OF DEATH: *[illegible]*
- SIGNATURE OF PHYSICIAN: *[illegible]*
- SIGNATURE OF REGISTRAR: *[illegible]*

BUREAU V. S.

AUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08313

CERTIFICATE OF DEATH

08308

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) JOHN T. MARBURG		4. DATE OF DEATH August 15 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1889
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sail Maker	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sail Maker		10b. KIND OF BUSINESS OR INDUSTRY Canvas Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Peter Marburg		14. MOTHER'S MAIDEN NAME Jennie Imhoff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 214-03-3814	
17. INFORMANT Clin. Rec. Vets. Admin. H		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE 541.0 DUE TO BLEEDING DUODENAL ULCER WITH OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUODENAL ULCER (c) 22 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ventricular hypertrophy and strain and/or anterio lateral myocardial 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) damage			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24 , 19 57 , to August 15 , 19 57 . that death occurred on the date stated above and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 8/16/57			
ACTUAL SIGNATURE Joseph M. Miller M.D. VAH Ft. Howard, Md		DATE SIGNED 8/16/57	
PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Director		ADDRESS 4101 Edmondson Ave. Balto. Md	
24a. REC'D BY REGISTRAR 2/20/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-10-1957

Name of Deceased		Date of Death	
John Doe		10-10-1957	
Age		35 years	
Sex		Male	
Race		White	
Marital Status		Married	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

AUG 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/55

08314

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 20 YEARS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3 VOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 920 NORTH MONROE ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle ELIZABETH Last MASK		4. DATE OF DEATH Month AUG Day 22 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM A. MASK		14. MOTHER'S MAIDEN NAME MARTHA E. KENNY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT Frank R. Smith Jr., Cockeysville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Vascular 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-26 , 19 50 , to 8-21 , 19 57 , that I last saw the deceased alive on 8-21 , 19 57 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Helen J. Coes		ADDRESS (Street, city or town, state) Cockeysville, Md	
DATE SIGNED 8/22/57			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-26-57	
22c. NAME OF CEMETERY OR CREMATORY Int. Olive X		22d. LOCATION (City, town, or county) (State) BALTO. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Coles Inc 1217 St Paul St		ADDRESS	
24a. REC'D BY REGISTRAR AUG 26 '57		24b. REGISTRAR'S SIGNATURE Outreach	

AUG 26 1957

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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. No. 0831044									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 291 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS 2513 E. Chase Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last MC CART			4. DATE OF DEATH Month August Day 15 Year 19 57						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/04		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph McCart				14. MOTHER'S MAIDEN NAME Barbara Reichert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT 217-16-1845 Clin. Rec. Vets. Admin. Hospital, Fort Howard, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX (SURGICALLY REMOVED) WITH METASTASES TO RIGHT PLEURA, RIGHT LUNG, KIDNEYS AND REGIONAL SUBCUTANEOUS TISSUE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 161X (c) 5 YEARS DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28 , 19 56 , to August 15 , 19 57 , and that death occurred at 6:23 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 8/16/57 ACTUAL SIGNATURE Chien Wei Lan M.D. Fort Howard, Maryland PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National			22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR Aug 19 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Taylor	

LEONARD J. RUCK FUNERAL HOME, 5305 Harford Rd, Balto., Md.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED John Henry		DATE OF DEATH August 19, 1957	
PLACE OF DEATH Home		AGE 65	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Roman Catholic	
BIRTH August 19, 1892		PLACE OF BIRTH Maryland	
FATHER'S NAME John Henry		MOTHER'S NAME Mary Jane	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Failure	
IMMEDIATE CAUSE Heart Failure		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED John Henry	
SIGNATURE OF WITNESS J. H. Smith		SIGNATURE OF DECEASED John Henry	

BUREAU V. S.

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08316

CERTIFICATE OF DEATH

08311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home		d. STREET ADDRESS 4008 Penhurst Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Hannah May McConkey		4. DATE OF DEATH Month Day Year Aug. 5, 1957 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Josiah Unger		14. MOTHER'S MAIDEN NAME Rebecca Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records of Presbyterian Home		Address Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardio-renal-vascular disease DUE TO (b) Senile changes DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1955 , to Aug 5, 1957 , that I last saw the deceased alive on Aug 1, 1957 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rollin C. Hudson M.D.		ADDRESS (Street, city or town, state) 606 Baltimore Ave Towson Md	
PHYSICIAN'S NAME (Type) Rollin C. Hudson MD		DATE SIGNED 8/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 7, 1957	22c. NAME OF CEMETERY OR CREMATORY Krieders	22d. LOCATION (City, town, or county) (State) Westminster, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR AUG 7 1957		24b. REGISTRAR'S SIGNATURE Mark Gay	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 8

AUG 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08312

08229

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>539 Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>McDonald</u> Last <u>McDonald</u>		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-13</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>King & Green Co. Va</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Cecil Lockley</u>	
14. MOTHER'S MAIDEN NAME <u>Vivian Brookening</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Helton</u> Address <u>539 Main St. Dundalk</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uterine Carcinoma</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1/57</u> to <u>August 15 1957</u> , that I last saw the deceased alive on <u>August 15 1957</u> , and that death occurred at <u>8:50 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.H. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>107 n. main st Balto</u> DATE SIGNED <u>22 Aug</u>	
PHYSICIAN'S NAME (Type) <u>J.H. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>2nd Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Little Plymouth Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel M. Sullivan Jr.</u> ADDRESS <u>Balto.</u>		24a. REC'D BY REGISTRAR <u>AUG 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

REG. NO. 11

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>10-15-57</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>NEW YORK</i>	
10. OCCUPATION <i>CLERK</i>		11. MARITAL STATUS <i>MARRIED</i>		12. EDUCATION <i>HIGH SCHOOL</i>	
13. PREVIOUS ILLNESS <i>NO</i>		14. PRESENT ILLNESS <i>NO</i>		15. MEDICAL HISTORY <i>NO</i>	
16. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		17. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>		18. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
19. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		20. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		21. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
22. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		23. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		24. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
25. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		26. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		27. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
28. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		29. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		30. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
31. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		32. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		33. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
34. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		35. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		36. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
37. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		38. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		39. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
40. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		41. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		42. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
43. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		44. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		45. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
46. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		47. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		48. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
49. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		50. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		51. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
52. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		53. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		54. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
55. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		56. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		57. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
58. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		59. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		60. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
61. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		62. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		63. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
64. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		65. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		66. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
67. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		68. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		69. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
70. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		71. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		72. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
73. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		74. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		75. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
76. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		77. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		78. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
79. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		80. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		81. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
82. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		83. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		84. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
85. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		86. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		87. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
88. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		89. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		90. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
91. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		92. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		93. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
94. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		95. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		96. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
97. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		98. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		99. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	
100. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		101. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		102. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>	

BUREAU V. 2

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08313

08317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Julie				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Gabrielle McEnroe				4. DATE OF DEATH Month Day Year Aug. 27, 1957 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1876	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas McEnroe				14. MOTHER'S MAIDEN NAME Hannah Sherlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Villa Julie Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Oesophagus. 150 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Nov 1956
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1956 to Aug 27, 1957 , that I last saw the deceased alive on Aug 24, 1957 , and that death occurred at 10:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Harold H Burns M.D.				PHYSICIAN'S NAME (Type) Harold N. Burns 115 E. AGER Ave. 2. md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-57		22c. NAME OF CEMETERY OR CREMATORY Trinity Convent Cem.		22d. LOCATION (City, town, or county) (State) Ilchester Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Swley Funeral Home, Catonsville Md				24a. REC'D BY REGISTRAR Aug 30 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION		EDUCATION		RELIGION		BIRTH		DEATH		BURIAL	
JAMES H. HARRIS		45		M		W		M		C		H		C		C		C		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
AUG 28 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		10 DAYS		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF INTERMENT		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF CHURCH		SIGNATURE OF OTHER	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
AUG 30 1957
BUREAU V. A.

CERTIFICATE OF DEATH

Reg. Dist. No.

08318

083188

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6205 Falls Rd.</u>				d. STREET ADDRESS <u>16205 Falls Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>Herbert</u> Last <u>McMahon</u>				4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1909</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City P.S.</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>C. McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Nora Pund</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u> <u>169X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-23-</u> , 19 <u>57</u> , to <u>8-28-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-28-</u> , 19 <u>57</u> , and that death occurred at <u>9P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benji B. Moses, M.D.</u>				ADDRESS (Street, city or town, state) <u>448 N. Luzerne Ave. Balto. Md.</u>			
DATE SIGNED <u>8-30-57</u>							
PHYSICIAN'S NAME (Type) <u>BENJ. B. MOSES, M.D.</u>				<u>Balto. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saturnia Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>				ADDRESS <u>130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mark Gay</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08315
08319 Item 2 Film 219 9-3-57 at
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE—HOME—OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Pennsylvania</i>		COUNTY <i>Allegheny</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Campbell Rd</i>		<i>1 year</i>		TOWN <i>Columbia, Pa.</i>		<i>75X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Augsburg Home</i>				STREET ADDRESS (If rural give location) <i>537 Locust Street</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<i>LOUISE MEHL</i>				OF DEATH: <i>8 27 1957</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 YRS.	
<i>female</i>	<i>white</i>	<i>single</i>	<i>June 21, 1869</i>	<i>88</i> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<i>None</i>				<i>None</i>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<i>Columbia Penn</i>				<i>USA</i>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John Christian Mehl</i>				<i>Maie K. Hoim</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.			
<i>None</i>				<i>None</i>			
17. INFORMANT & ADDRESS:							
<i>Augsburg Home, Fulton P. Tyler</i>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) - - <i>Carcinoma of Uterus</i>							<i>8 mo.</i>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
<i>Arterio - Sclerotic Heart Disease -</i>							<i>5 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>None</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>June</i> , 1957, to <i>8/27</i> , 1957, that I last saw the deceased alive on <i>8/20</i> , 1957, and that death occurred at <i>M. from the causes and on the date stated above.</i>							
SIGNATURE <i>Paul L. Chambers</i>				ADDRESS <i>4108 Liberty Hts C Balt - Md - 8-27-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>8-27-57</i>		<i>Columbus Pa.</i>			
DATE REC'D BY LOCAL REGISTRAR <i>8/27</i>		REGISTRAR'S SIGNATURE <i>Dr. H. H. Madsen</i>		24. FUNERAL DIRECTOR <i>Paul A. Legman</i>		ADDRESS <i>60007 Halford Rd.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 29 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08320

08316

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 18 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 8704 Raven Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8704 Raven Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARLAND Middle R. Last MORGAN		4. DATE OF DEATH Month August Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/14
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beckley Radio.		10b. KIND OF BUSINESS OR INDUSTRY West. VA.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C. C. MORGAN		14. MOTHER'S MAIDEN NAME LAURA B. MORGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Records	
17. INFORMANT Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Alcoholism. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Monte Vista	22d. LOCATION (City, town, or county) (State) Princeton N. VA.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Fisher & Son		24a. REC'D BY REGISTRAR SEP 3 1957	
ADDRESS 11211 Mt. Royal Ave		24b. REGISTRAR'S SIGNATURE Hubert Gray	

BUREAU V. 8

SEP 3 1957

RECEIVED

[Handwritten signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

08230

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08317

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 53</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1963 DENBURY ROAD</u>				d. STREET ADDRESS <u>1963 DENBURY ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>P.</u> Last <u>MORISI</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG-22 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMIL MORISI</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE BRUNETTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-01-2008</u>		17. INFORMANT Address <u>MRS CATHERINE MORISI 1963 DENBURY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 27 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME DUNDALK MD</u>				24a. REC'D BY REGISTRAR <u>AUG 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5.

AUG 28 1957

RECEIVED

08321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08318 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. LENGTH OF STAY IN 1b <u>54 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH P. MYER</u>		4. DATE OF DEATH <u>Aug 6-1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 9-1862</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Logan Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Myer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Philips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Isabel F. Myer</u>		Address <u>7922 Ellenham Rd. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>Unk</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 6, 1957</u> , to <u>Aug 6, 1957</u> , that I last saw the deceased alive on <u>Aug 6, 1957</u> , and that death occurred on <u>Aug 6, 1957</u> at <u>5:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennett A. Stoen</u>		ADDRESS (Street, city or town, state) <u>Riverhill</u>	
PHYSICIAN'S NAME (Type) <u>BENNETT A. STOEN</u>		DATE SIGNED <u>8/7/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 9-1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Son Towson 4</u>		24a. REC'D BY REGISTRAR <u>AUG 9 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Isabel Myer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE	
JAMES EARL RAY		APR 14 1928		MALE		WHITE		MARRIED		HIGH SCHOOL		CLERK		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
APR 4 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		YES		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
10:00 PM		MEMPHIS, TENN.		HEART DISEASE		NATURAL		YES		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
APR 4 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		YES		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
 AUG 9 1967
 BUREAU V. 1

08231

CERTIFICATE OF DEATH

08319

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>OHIO</u> b. COUNTY <u>JEFFERSON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TORONTO</u> 72X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6732 WOODLEY RD</u>				d. STREET ADDRESS <u>210 N. THIRD AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>URBAN</u> Last <u>O'BRIEN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 SEPT</u>		9. AGE (In years lost birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MICHAEL O'BRIEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY KELLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. FRANK WRIGHT -</u>		Address <u>6732 WOODLEY RD DUNDALK</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-25</u> , 19 <u>57</u> , to <u>8-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-16</u> , 19 <u>57</u> , and that death occurred at <u>11 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Kingship Baltimore 22 Md</u> DATE SIGNED <u>8-17-57</u>							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. <u>2 Kingship</u>			
PHYSICIAN'S NAME (Type) <u>JACK COLLINS</u>				<u>BALTIMORE 22 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TORONTO UNION</u>		22d. LOCATION (City, town, or county) (State) <u>TORONTO, OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Kelly</u> ADDRESS <u>Dundalk, Md</u>				24a. REC'D BY REGISTRAR <u>Wm. Kelly</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

CERTIFICATE OF DEATH

See Ord. No.

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. DATE OF DEATH [Faint handwritten date]</p>	
<p>7. TIME OF DEATH [Faint handwritten time]</p>		<p>8. PLACE OF DEATH [Faint handwritten place]</p>	
<p>9. CAUSE OF DEATH [Faint handwritten cause]</p>		<p>10. MANNER OF DEATH [Faint handwritten manner]</p>	
<p>11. SIGNATURE OF DECEASED [Faint handwritten signature]</p>		<p>12. SIGNATURE OF WITNESS [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>		<p>14. SIGNATURE OF CLERK [Faint handwritten signature]</p>	
<p>15. SIGNATURE OF JURY [Faint handwritten signature]</p>		<p>16. SIGNATURE OF JUDGE [Faint handwritten signature]</p>	
<p>17. SIGNATURE OF SHERIFF [Faint handwritten signature]</p>		<p>18. SIGNATURE OF CORONER [Faint handwritten signature]</p>	
<p>19. SIGNATURE OF TOWNSHIP CLERK [Faint handwritten signature]</p>		<p>20. SIGNATURE OF COUNTY CLERK [Faint handwritten signature]</p>	

BUREAU V. 8

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08322

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08320

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>				c. LENGTH OF STAY IN b. <u>4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>144 MURDOCK RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>O'BRIEN</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 21, 1915</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HE HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>William J Larkin</u>				14. MOTHER'S MAIDEN NAME <u>Nester Ingram</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-1727</u>		17. INFORMANT <u>Nbsp CHARL BON SECOURS</u> Address <u>2025 W Fayette</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175X Papillary cystadenoma carcinoma of ovary</u> DUE TO (b) <u>Dissecting abdominal aortic aneurysm</u> DUE TO (c) <u>Gastroenteritis - symmetrical villous</u> lying cause lost. <u>Small intestine, peritonitis, hemorrhagic shock</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u> <u>5 mo</u> <u>3 mo</u> <u>2 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcerative colitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>56</u> , to <u>Aug 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 4</u> , 19 <u>57</u> , and that death occurred at <u>10 54 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. D. Sullivan</u>				ADDRESS (Street, city or town, state) <u>1129 St Paul St</u>			
DATE SIGNED <u>Aug 10, 1957</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 13, 1957</u>		<u>New Calhoun</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Crumpton</u>				ADDRESS <u>118 W. Mt. Royal Ave</u>		24a. REC'D BY REGISTRAR <u>AUG 14 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Malcolm Gray</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>William J. Linkin</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>44</i></p>		<p>4. DATE OF BIRTH <i>May 21, 1913</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>None</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>	
<p>9. DATE OF DEATH <i>Aug 14, 1957</i></p>		<p>10. TIME OF DEATH <i>10:00 AM</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>	

BUREAU V. S.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08323

CERTIFICATE OF DEATH

08321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CEDAR BEACH				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CEDAR BEACH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOX 115 POPLAR RD.				d. STREET ADDRESS BOX 115 POPLAR RD.			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES LUKE O'CONNOR				4. DATE OF DEATH Month Day Year AUG. 8 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 6 - 1886		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED				11b. KIND OF BUSINESS OR INDUSTRY BARBER		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY? SELF EMPLOYED				13. FATHER'S NAME O'CONNER			
14. MOTHER'S MAIDEN NAME CAROLINE O MIESE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address DORA O'CONNOR SAME AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary carcinoma DUE TO metastatic (c)							INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from 8/7 , 19 57 , to 8/8 , 19 57 , that I last saw the deceased alive on 8/7 , 19 57 , and that death occurred at 8:00 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. PLATT				ADDRESS (Street, city or town, state) 454 Eastern Ave.			
PHYSICIAN'S NAME (Type) J. PLATT				DATE SIGNED EARLY MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/12/57		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Connelly				ADDRESS 418 Eastern Ave		24a. REC'D BY REGISTRAR DATE AUG 13 1957	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

22

RECEIVED

BUREAU V. 8.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08324

CERTIFICATE OF DEATH

08322-4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5932 Marluth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUST Middle - Last OYOSOSKI				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1887	
				9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY City government		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Frank Oyososki				14. MOTHER'S MAIDEN NAME Minnie MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 215-22-3034		17. INFORMANT Address Glin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) OLD CEREBRAL INFARCTION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from July 30, 1957 , to August 6, 1957 and that death occurred at 5:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 8/8/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James L. McGully Funeral Home, 237 Patapsco St.				24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE L. L. Larkins	

CERTIFICATE OF DEATH

MAKLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF CLERK [Illegible]	

RECEIVED
 AUG 12 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08325

CERTIFICATE OF DEATH

08323 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 84 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1216 N. BRADFORD STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANCIS Middle A. Last PODZIMEK				4. DATE OF DEATH Month AUGUST Day 16, Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 19, 1924	
9. AGE (In years lost birthday) yrs. 33		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVENTORY CLERK				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WENCESLAUS PODZIMEK				14. MOTHER'S MAIDEN NAME HELEN HRADSKY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 9-30-50/1-31-52 216-14-4559		17. INFORMANT Address CLIN. REC., VET. ADM. HOSP., FT. HOWARD, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ILEITIS; INTESTINAL POLYPOSIS; DURATION UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 19 57, to August 16, 19 57 and that death occurred at 5:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 8-16-57 ACTUAL SIGNATURE T. Lawrence Fleisher M.D. PHYSICIAN'S NAME (Type) T. Lawrence Fleisher M.D. VAH, Fort Howard, Maryland 8-16-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvach, 2716-18 E. Monument St., Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE AUG 19 1957 24b. REGISTRAR'S SIGNATURE Deason L. Taylor			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

1957

DATE OF DEATH

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BUREAU V. S.

AUG 19 1957

RECEIVED

08326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>736 Edmondson Avenue</i>		d. STREET ADDRESS <i>1 736 Edmondson Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Sadie L. Pohlhaus</i>		4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 7, 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Lafferty</i>		14. MOTHER'S MAIDEN NAME <i>Bridget ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Bernard V. Pohlhaus,</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Degenerative Cardiovascular Disease</i> DUE TO <i>Coronary sclerosis and insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Myocardial failure</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>May</i> 19 <i>55</i> , to <i>20 Aug.</i> 19 <i>57</i> , that I last saw the deceased alive on <i>20 Aug.</i> 19 <i>57</i> , and that death occurred at <i>3:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1725 North Charles Street</i> DATE SIGNED <i>8/20/57</i>			
ACTUAL SIGNATURE <i>Joseph E. Muse, Jr.</i>		M.D. <i>1725 North Charles Street</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Muse, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/23/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>Aug 22 '57</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22 AUG 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 02198-19-57 et

CERTIFICATE OF DEATH

08325

Reg. Dist. No.

32

08327

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY CITY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 1323 W. FAYETTE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Meta Meta Daniels POTTER				4. DATE OF DEATH Aug. 10 th 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-24-04	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) WILMINGTON, DEL.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME SEORSE W. DANIELS				14. MOTHER'S MAIDEN NAME ANNA MAY CONROY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-093633			
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FEAR ADVANCED PULMONARY TBC 002X DUE TO 2. CARDIAC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH about 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-8- 1957 , to 8-10 1957 , that I last saw the deceased alive on 8-10- 1957 , and that death occurred at 1:20 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D.							
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-57		22c. NAME OF CEMETERY OR CREMATORY Silverbrook		22d. LOCATION (City, town, or county) (State) Wilmington Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner Sons				24a. REC'D BY REGISTRAR DATE 8/13/57		24b. REGISTRAR'S SIGNATURE Dorothy Russell	

BUREAU V. S.

AUG 14 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08232

CERTIFICATE OF DEATH

0832641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bundick</u>		c. LENGTH OF STAY IN 1b <u>15 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2604 Gray Manor Terrace</u>		d. STREET ADDRESS <u>2604 GRAY MANOR TERR.</u>	
3. NAME OF DECEASED (Type or print) <u>TINCY E</u> First Middle Last <u>PUCKETT</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-14</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacy Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN AIR.</u>	
11. BIRTHPLACE (State or foreign country) <u>WILKES BARRE N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE LANGFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robt. H. PUCKETT</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNDERNUTRITION</u> DUE TO (c) <u>Generalized Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10, 1957</u> to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 17, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Orlando Berrios</u> M.D.		ADDRESS (Street, city or town, state) <u>2903 W. Woodwell Rd.</u>	
PHYSICIAN'S NAME (Type) <u>OSCAR L. BERRIOS M.D.</u>		DATE SIGNED <u>8/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 28, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Kelly</u> ADDRESS <u>21431 E. Oliver St.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>	

BUREAU V. S.

AUG 23 1957

RECEIVED

08328

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fullerton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8321 Belair Road</u>				d. STREET ADDRESS <u>8321 Belair Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Agness</u> Last <u>Raab</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/1862</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Anton Paul</u>				14. MOTHER'S MAIDEN NAME <u>Agnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Henry A. Raab</u> Address <u>8321 Belair Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19 <u>49</u> , to <u>Aug 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R Donald Jandorf</u>				ADDRESS (Street, city or town, state) <u>6077 Harford Rd, Balt 14, Md</u>			
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>				DATE SIGNED <u>8-13-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel Funeral Home</u>				ADDRESS <u>2401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Mr. L. L. Thompson</u>	
				DATE <u>AUG 15 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Ord. No.

DEATH OF A PERSON WHOSE DEATH WAS REPORTED TO THE HEALTH DEPARTMENT BY A PHYSICIAN OR OTHER PERSON QUALIFIED BY LAW TO REPORT DEATHS.		DEATH OF A PERSON WHOSE DEATH WAS REPORTED TO THE HEALTH DEPARTMENT BY A PHYSICIAN OR OTHER PERSON QUALIFIED BY LAW TO REPORT DEATHS.	
NAME OF DECEASED LAST NAME FIRST NAME MIDDLE NAME SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH STREET CITY STATE ZIP		TIME OF DEATH HOUR MINUTE	
CAUSE OF DEATH (List all causes, beginning with the immediate cause, and giving the underlying cause last.)		MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)	
AGED <input type="checkbox"/> YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
RACE <input type="checkbox"/> WHITE <input type="checkbox"/> NEGRO <input type="checkbox"/> OTHER		BIRTH DATE <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	
PLACE OF BIRTH <input type="checkbox"/> STATE <input type="checkbox"/> FOREIGN		DATE OF BIRTH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	
OCCUPATION		EDUCATION	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		RELIGION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
PREVIOUS TRAUMA		PREVIOUS DRUGS	
PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
PREVIOUS OTHER		PREVIOUS OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REPORTER	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

AUG 15 1957

RECEIVED

08329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3 Vol-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pine Nursing Home</u>				d. STREET ADDRESS <u>611 Whitelock St.</u>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Raffel</u> First Middle Last				4. DATE OF DEATH <u>Aug. 7/57</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop.</u>		11. BIRTHPLACE (State or foreign country) <u>Cyprus</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Raffel</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Isaacson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Rose Raffel - 611 Whitelock St.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General + cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19, to <u>8/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton B. Kirsh</u>				ADDRESS (Street, city or town, state) <u>2370 Rutaw Place</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Milton B. Kirsh, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Grounds</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Feinman & Bros. Inc.</u> ADDRESS <u>1124-26</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08330

CERTIFICATE OF DEATH

08329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Kingsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Kingsville</u>			
c. LENGTH OF STAY IN 1b <u>7 years</u>				d. STREET ADDRESS <u>Sunshine Avenue Kingsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sunshine Avenue Kingsville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle Last <u>Rode</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William Emmart</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Sachs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Helen Ritchie</u> Address <u>Sunshine Ave. Kingsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cordic Dilatation</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>year</u> <u>15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>August 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>57</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William L. Feoring</u> M.D.				ADDRESS (Street, city or town, state) <u>3025 Belair Road</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassman Funeral Home</u>				ADDRESS <u>2401 Belair Rd.</u>			
24b. REC'D BY REGISTRAR <u>AUG 15 1957</u>				24c. REGISTRAR'S SIGNATURE <u>Dr. Walter H. H. H.</u>			

BUREAU V. S.

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

08330

08331

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>4208 Waldman Ave</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Jones Creek</u>		STREET ADDRESS (If rural, give location) <u>4208 Waldman Ave</u>	
3. NAME OF DECEASED (First) <u>Alonso</u> (Middle) <u>Lee</u> (Last) <u>Rose</u>		4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>25</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Booze Bros</u>	
13. FATHER'S NAME <u>Robert Rose</u>		14. MOTHER'S MAIDEN NAME <u>Annagene Ashburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mr Rose 4208 Waldman Ave</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a)

Chronic Congestive Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Arterioscl. Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 year+ 10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1957 to Aug 25, 1957, that I last saw the deceasedalive on Aug 23, 1957, and that death occurred at 11 a.m., from the causes and on the date stated above.SIGNATURE Alonso Lee Rose(Degree or title) M.D.ADDRESS 520 D St Balt 19DATE SIGNED 8-26-57

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF Aug 28 1957NAME OF CEMETERY OR CREMATORY Meadow RidgeLOCATION (City, town, or county) Worrey Md

(State)

DATE RECEIVED BY LOCAL REGISTRY AUG 27 1957REGISTRAR'S SIGNATURE Samson L. Farley24. FUNERAL DIRECTOR Geo. S. LeachADDRESS 1701-03 Patterson Park Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 28 1957

BUREAU V. S.

C8332
CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Granite			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Old Court Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Love Rupp				4. DATE OF DEATH Month Day Year August 16 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1875		9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Henry Love				14. MOTHER'S MAIDEN NAME Ann Hall Worthington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Augusta R. Monroe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE C.V. DISEASE DUE TO (c) RENAL INSUFFICIENCY						INTERVAL BETWEEN ONSET AND DEATH 10 days - 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from JUNE 1 , 1950, to AUG-16 , 1957, that I last saw the deceased alive on AUG 16 , 1957, and that death occurred at 1 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Wheeler				ADDRESS (Street, city or town, state) 3601 Cypress Rd - Balt - Md			
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER				DATE SIGNED 8/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Worthington Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Ellsworth Armacost - 4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR AUG 20 1957	
				24b. REGISTRAR'S SIGNATURE Dr. M. E. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

AUG 20 1957

RECEIVED

08333

CERTIFICATE OF DEATH

08332

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3647 KEYSTONE AVENUE			
3. NAME OF DECEASED (Type or print) First LEONARD Middle A. Last SARACIN				4. DATE OF DEATH Month AUGUST Day 28 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 27, 1910	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Man		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) BRIDGEPORT, CONNECTICUT		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK P. SARACIN				14. MOTHER'S MAIDEN NAME MARGARET SALVANGNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 048-01-6657		17. INFORMANT CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNLISTED TUMOR OF LUNG, MALIGNANT 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that attended the deceased from August 23 , 19 57 , to August 28 , 19 57 , XXXXXXXXXXXXXXXXXXXX and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 8/29/57							
ACTUAL SIGNATURE Abraham A. Polachek M.D.				PHYSICIAN'S NAME (Type) ABRAHAM/POLACHEK, M.D. Asst. Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-29-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery BRIDGEPORT, CONNECTICUT		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS Wm Cook-Blight, Inc. 6009 Harford Rd, Baltimore 14, MD.				24a. REC'D BY REGISTRAR 9/4/57		24b. REGISTRAR'S SIGNATURE Dawson L. Parker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED TO:

RICHARD SPABACCINO, 499 WASHINGTON AVE., BRIDGEPORT, CONN.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 5 MAY 1928		PLACE OF BIRTH MOBILE, ALABAMA	
MARRIAGE MARRIED		DATE OF MARRIAGE 1950		PLACE OF MARRIAGE MEMPHIS, TENNESSEE	
OCCUPATION MEMBER OF CONGRESS		DATE OF DEATH 4 APRIL 1968		PLACE OF DEATH MEMPHIS, TENNESSEE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF REPORT 10 APRIL 1968	
REPORTED BY JAMES EARL RAY		SIGNATURE JAMES EARL RAY		DATE 10 APRIL 1968	

BUREAU V. 8

SEP 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

08334

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rural: Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 15 3V 4-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS (If rural give location) <u>2540 Gunther Ave</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>PHILIP</u>		(Middle)		(Last) <u>SCHEININ</u>	
4. DATE OF DEATH:		(Month) <u>8</u>		(Day) <u>24</u>		(Year) <u>1957</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>10/11/1892</u>		9. AGE last birthday: <u>64</u> yrs.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Servant Factory</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob Scheinin</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Berlin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Carcinoma Lung</u>							<u>10 mos</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Aug 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 16</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Milton B. Kuss</u>		<u>M.D.</u>		<u>Eudowood Sanatorium - Towson 4, Maryland</u>		<u>8/24/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-25-57</u>		<u>Rosedale</u>		<u>Balto, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>AUG 25 1957</u>		<u>H. H. Williams, M.D.</u>		<u>Jaess Lewis</u>		<u>2100 Eastern Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUG 28 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
D
M
50
1
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08335

CERTIFICATE OF DEATH

Reg. Dist. No.

08334
44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 39 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle SCHMIDT, JR. Last SCHMIDT, JR.				4. DATE OF DEATH Month August Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1914	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Schmidt, Sr.				14. MOTHER'S MAIDEN NAME Lillian Siebert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 214-26-8168			
17. INFORMANT Clin. Rec., Vet. Administration Hospital, Ft.				Address Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE AND SUBARACHNOID 330x DDDD HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 or 3 Hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. VA p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 13 , 19 57 , to August 21 , 19 57 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 8/21/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FT HOWARD, MD 8/21/57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH., FT HOWARD, MD 8/21/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF AUG 23-1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National CEM		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dippel Bros. John J. Dippel				24a. REC'D BY REGISTRAR AUG 22 Dawson L. Farber			
24b. REGISTRAR'S SIGNATURE 7100 Belair Rd, Balto, Md							

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-12-28		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
4-4-68		BALTIMORE, MD		HEART DISEASE	
MANNER OF DEATH		OCCUPATION		EDUCATION	
NATURAL		CONTRACTOR		HIGH SCHOOL	
MARITAL STATUS		RELIGION		SPECIAL OCCASION	
MARRIED		METHODIST		NONE	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
DR. J. H. HARRIS		JAMES EARL RAY FUNERAL HOME		GREENWOOD CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]	

BUREAU V. 5

AUG 23 1967

RECEIVED

08336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO NOTCH CLIFF NEAR TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENARM ROAD</u>		d. STREET ADDRESS <u>1 GLENARM ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARY SOPHIE SCHULTE</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 8 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8 1862</u>
9. AGE (In years last birthday) yrs. <u>94</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
13. FATHER'S NAME <u>AUGUST</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GRANITATH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SISTER M. PETER FOURIER</u>		Address <u>NOTCH CLIFF</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PEMPHIGUS</u> <u>7041</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1953</u> , to <u>AUGUST 1957</u> , that I last saw the deceased alive on <u>JULY 30, 1957</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 YORK ROAD TOWSON 4, Md. 8/9/57</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM</u>	22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Guler</u>		24a. REC'D BY REGISTRAR DATE <u>8/9/57</u>	
ADDRESS <u>901 S. CONKLING ST BALTO., 24, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Guler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 6219 8-9-57 et

08337

CERTIFICATE OF DEATH

08336

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randellstown, Maryland</u>		c. LENGTH OF STAY IN 1b <u>about 5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wards Chapel Rd.</u>		d. STREET ADDRESS <u>1310 Asquith st.</u>	
3. NAME OF DECEASED (Type or print) <u>William J. Schuman</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1893</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Assessor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Express</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lena Schuman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>714-03-4040</u>	
17. INFORMANT <u>Andrew J Schuman</u>		Address <u>-3333 Eppa Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-27</u> , 19 <u>57</u> , to <u>8-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-31</u> , 19 <u>57</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon Ashman</u>		M.D. <u>5907 Argonne Oak Ave</u> <u>8:25</u>	
PHYSICIAN'S NAME (Type) <u>LEON ASHMAN</u>		<u>Balto, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens - Bel Air Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Ruth Inc</u>		ADDRESS <u>1735 Hanford Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Martin</u>	

BUREAU V. S.

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND

08338

CERTIFICATE OF DEATH

08338

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> X 2		d. STREET ADDRESS <u>207 Sudbrook Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Frances Shipley</u>		4. DATE OF DEATH Month Day Year <u>August 25 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Garrish</u>		14. MOTHER'S MAIDEN NAME <u>Kathrine Lorey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>219-10-2942</u>	
17. INFORMANT <u>Mrs. Glen Shipley</u>		Address <u>Pikesville 207 Sudbrook Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170x</u> DUE TO (c) <u>14x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 24</u> , 19 <u>56</u> , to <u>Aug 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 24</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pikesville - Md</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		DATE SIGNED <u>8/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR <u>27 1957</u>	
ADDRESS <u>Pikesville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Donna Newell</u>	

BUREAU V. S.

AUG 27 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08339

CERTIFICATE OF DEATH

08338 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home 301 West Chesapeake Avenue				d. STREET ADDRESS 6436 Blenheim Road			
3. NAME OF DECEASED (Type or print) First Edith Middle Strouss Last Shore				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1902		9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A. Strouss				14. MOTHER'S MAIDEN NAME Caroline J. Gilmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. M. Shore, 6436 Blenheim Road, Baltimore 12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Descending Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 10, 1957 , to Aug 6, 1957 , that I last saw the deceased alive on Aug 6, 1957 , and that death occurred at 12:40 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Laurence C. Post				ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore 12 Md			
PHYSICIAN'S NAME (Type) LAURENCE C. POST M.D.				DATE SIGNED 8/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-57		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Norristown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 8/9/57		24b. REGISTRAR'S SIGNATURE Malcolm G. [Signature]	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John A. Smith		45		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		August 12, 1957		10:30 AM		J. A. Smith		J. B. Jones		J. C. Doe	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Baltimore, Md.		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957	
Place of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Home		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957	
Cause of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Heart Disease		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957	
Place of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Home		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957	
Cause of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Heart Disease		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957		August 12, 1957	

RECEIVED
AUG 12 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08340

CERTIFICATE OF DEATH

083394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle S. Last SIX				4. DATE OF DEATH Month August Day 2 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 20, 1890	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) White Hall, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jerry Six			
14. MOTHER'S MAIDEN NAME Jane Wilson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I			
16. SOCIAL SECURITY NO. 218-05-0249				17. INFORMANT Clin Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PENIS (SURGICALLY REMOVED) WITH SKIN AND REGIONAL LYMPHOID METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX DUE TO XX (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA RIGHT LOWER LOBE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 21, 19 57 to August 2, 19 57 , that death occurred at 2:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 8/3/57							
ACTUAL SIGNATURE Chien Wei Lan				M.D. Veterans Administration Hospital			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5/1957		22c. NAME OF CEMETERY OR CREMATORY West Liberty Cemetery		22d. LOCATION (City, town, or county) (State) Whitehall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa.				24. REG'D BY REGISTRAR Aug 6 1957			
25. REGISTRAR'S SIGNATURE Dawson L. Turkey							

VS A15 (4)
15M 9/55

Hartenstein Funeral Home, New Freedom, Pa.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

UG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08340

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Falls Rd</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Kirklyn</u> Middle <u>Smith</u> Last				4. DATE OF DEATH <u>August 21</u> Month <u>21</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12, 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Smith</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215323304</u>		17. INFORMANT <u>Ethel Smith</u> Address <u>Route 2 Brandywine Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>57</u> , to <u>Aug 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Aug</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville</u> DATE SIGNED <u>21 Aug 1957</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>				<u>Cockeysville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gough Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>8-21-57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mary B Eline</u>	

CERTIFICATE OF DEATH

22

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARITAL STATUS	
PREVIOUS ILLNESS		CAUSE OF DEATH	
IMMEDIATE CAUSE		MEDICAL OPINION	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 8

AUG 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808341
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1920 Crafton Ave.		d. STREET ADDRESS 1920 Crafton Ave.	
3. NAME OF DECEASED (Type or print) Willard R. Snyder		4. DATE OF DEATH Month Aug. Day 29 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sample Carrier		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Dixon City-Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder		14. MOTHER'S MAIDEN NAME Ellen Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 199-09-5249	
17. INFORMANT M. Emma Snyder		Address 1920 Crafton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) June	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M-B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 9-2-57	
22c. NAME OF CEMETERY OR CREMATORY Christ Luth. Cem.		22d. LOCATION (City, town, or county) (State) German Hill Rd.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.		ADDRESS -2431 E. Oliver St.	
24a. REC'D BY REGISTRAR SEP 3 1957		24b. REGISTRAR'S SIGNATURE John Kelly	

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SEP 3 1957

BUREAU V. S.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

FOR STATE
HEALTH DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08342

CERTIFICATE OF DEATH

08342

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moreland Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 54			
				d. STREET ADDRESS 330 Townsend Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARRIE Middle MAY Last STOVER				4. DATE OF DEATH Month August Day 18 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Christopher H. Stover				14. MOTHER'S MAIDEN NAME Cecelia B. Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. No.			
17. INFORMANT Jennie Simmons				Address 330 Townsend Ave-21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic H.P. Disease DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 hrs 5 mos 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 5 , 19 56 , to Aug 18 , 19 57 , that I last saw the deceased alive on Aug 18 , 19 57 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Meerns				ADDRESS (Street, city or town, state) 520 N. St. Baltimore Md			
PHYSICIAN'S NAME (Type) James T. Meerns				DATE SIGNED 8/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Columbia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home				ADDRESS 4210 Belair Road.		24a. REC'D BY REGISTRAR DATE 8/20/57	
				24b. REGISTRAR'S SIGNATURE Jawson L. Farley			

MEDICAL CERTIFICATION

BUREAU V. S.

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08343

CERTIFICATE OF DEATH

083433
Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>ALVIN - R - STREUBIG</u>				4. DATE OF DEATH <u>Aug 28</u> 19 <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 - 1879</u>	9. AGE (In years, last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>now worker</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ephraim B Streubig</u>				14. MOTHER'S MAIDEN NAME <u>Irene Froebel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-05-7129</u>			
17. INFORMANT <u>Mrs Alvin Streubig</u>				Address <u>Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary - Insufficiency</u> DUE TO (c) <u>Asteris - Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 y 20</u> <u>15 y 20</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Aug 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>57</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
DATE SIGNED <u>8/31/57</u>							
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>				Hampstead, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 31/57</u>		<u>Grave Run</u>		<u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Lipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>8-31-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary B Fine</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]		CITY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]		TELEPHONE [Faint text]	

RECEIVED

SEP 4 1957

BUREAU V. 1

12-31-21

08344

08344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3V01-4			
c. LENGTH OF STAY IN b. <u>3 years</u>				d. STREET ADDRESS <u>4308 Stanwood Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Aged Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur D. Swan</u>				4. DATE OF DEATH Month Day Year <u>August 1 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>				13. FATHER'S NAME <u>Charles Thomas Swan</u>			
14. MOTHER'S MAIDEN NAME <u>Laura Bollman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War I</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract infection & septicemia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostate hypertrophy</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-28</u> , 19 <u>54</u> , to <u>present</u> , 19 <u>57</u> that I last saw the deceased alive on <u>7/31</u> , 19 <u>57</u> , and that death occurred at <u>4</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 N. Calvert St - 2</u> DATE SIGNED ACTUAL SIGNATURE <u>Ernest C Brown</u> M.D. PHYSICIAN'S NAME (Type) <u>ERNEST C BROWN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ulrich Funeral Homes Balto Md</u>				24a. REC'D BY REGISTRAR <u>AUG 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08345

08239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 (Arbutus) 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5528 Council St.				d. STREET ADDRESS 5528 Council St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSS Middle PRICE Last TARR				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1897	
9. AGE (In years last birthday) 60 yrs.		10. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Automotive			
13. FATHER'S NAME Richard Simpers Tarr				14. MOTHER'S MAIDEN NAME Mary Victoria Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-8960		17. INFORMANT Helen A. Tarr, Baltimore 27, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - upper lobe - pt. lung - with 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitoses to liver - DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 8 mos +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓			
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to Aug 1 , 19 57 , that I last saw the deceased alive on July 31st, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1014 Frances Ave - Balto 27 - Md DATE SIGNED							
ACTUAL SIGNATURE Frederic O. Butler				M.D. 1014 Frances Ave - Balto 27 - Md			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-57		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR AUG 6 1957		24b. REGISTRAR'S SIGNATURE Dr. M. Kieffer	

CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] RACE: [REDACTED] DATE OF BIRTH: [REDACTED]

PLACE OF BIRTH: [REDACTED] DATE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED]

BUREAU V. 3

1957 6 AUG

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08345

CERTIFICATE OF DEATH

08346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1022 HART RD.				d. STREET ADDRESS 1 1022 HART RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last AMBROSE MEADE TAYLOR				4. DATE OF DEATH Month Day Year AUG 30 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-65	9. AGE (In years last birthday) 9.2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) PA.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME THOMAS TAYLOR				14. MOTHER'S MAIDEN NAME JULIANN ORNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MRS. BRADFORD PETERSON				Address 1022 HART RD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIP 140X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 MOS.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 57 , to Aug 30 , 19 57 , that I last saw the deceased alive on Aug 28 , 19 57 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE William A. Pillsbury M.D.				TIMONILUM MD 8/30/57			
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Brandonville Adams Co Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Milton Bender				ADDRESS Gettysburg, Pa.		24a. REC'D BY REGISTRAR SEP 3 1957	
				24b. REGISTRAR'S SIGNATURE Metel Gray			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		DATE OF DEATH <i>Sept 1 1957</i>	
AGE <i>45</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Engineer</i>		MARITAL STATUS <i>Married</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		DATE OF BIRTH <i>Aug 15 1912</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
SIGNATURE OF DECEASED <i>John A. Smith</i>		SIGNATURE OF WITNESSES <i>Dr. J. H. Jones, Mrs. J. A. Smith</i>	
DATE OF FILING <i>Sept 3 1957</i>		FILING OFFICE <i>Baltimore, Md.</i>	

BUREAU V. 1

SEP 3 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08346

08347

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 mo. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville 02X22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First John Middle H. Last Thomas			4. DATE OF DEATH Month 8 Day 21 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH ?		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Thomas Thomas			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Records of Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Aug. 57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
22d. LOCATION (City, town, or county) Glen Burnie, Maryland		22e. REC'D BY REGISTRAR DATE AUG 27 57		24b. REGISTRAR'S SIGNATURE <i>W. L. Leach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 27 1957

BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08234

CERTIFICATE OF DEATH

08348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 20 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 118 Williams Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First W. Middle ALBERT Last THUMA, SR.				4. DATE OF DEATH Month August Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1895	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor		10b. KIND OF BUSINESS OR INDUSTRY tea room		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Willis A. Thuma			
14. MOTHER'S MAIDEN NAME Louise Bechtold				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 219-20-6068				17. INFORMANT Mrs. M. Elizabeth Thuma-118 Williams Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) Baltimore			20g. (County) Baltimore			20h. (State) Maryland	
21. I certify that I attended the deceased from 48 to 29 Aug. , 19 57 , that I last saw the deceased alive on 29 August 1957 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. W. Soklod, M.D.				ADDRESS (Street, city or town, state) 2900 Dundalk Rd Dundalk - Md			
DATE SIGNED 8-30-57				PHYSICIAN'S NAME (Type) B. W. SOKLOD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.				ADDRESS Baltimore, Md.			
24a. REC'D BY REGISTRAR SEP 3 1957				24b. REGISTRAR'S SIGNATURE Mr. Kelly			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

SEP 3 1957

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NAME (Last, First, Middle)		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APR 22 1928		MOBILE, ALABAMA	
RACE		SEX		MARRIAGE	
WHITE		MALE		SINGLE	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
APR 4 1968		MEMPHIS, TENNESSEE		SUICIDE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF ENTRY		PLACE OF ENTRY		MANNER OF ENTRY	
APR 4 1968		MEMPHIS, TENNESSEE		SUICIDE	

08347

CERTIFICATE OF DEATH

08349 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Long Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Chesapeake Avenue			
3. NAME OF DECEASED (Type or print) First HARRY Middle H Last TROST				4. DATE OF DEATH Month Aug. Day 18 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1886	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Own Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Trost		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Laura A. Henze Trost, wife, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 8 yrs 3 yrs 10 + yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthmatic bronchitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. , 19 56 , to 8/18 , 19 57 , that I last saw the deceased alive on 8/16 , 19 57 , and that death occurred at 9: A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. PLATT, M.D.				ADDRESS (Street, city or town, state) 434 Eastern Ave. Essex, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED 8/19/57			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane				24a. REC'D BY REGISTRAR DATE 21 1957		24b. REGISTRAR'S SIGNATURE Edith Hawley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG219 8-30-57 et

CERTIFICATE OF DEATH

08348

08350

Reg. Dist. No.

22

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1523 MARSHALL STREET	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle TRUST Last TRUST		4. DATE OF DEATH Month AUGUST Day 22 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4. 30. 01
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTERER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN TRUST		14. MOTHER'S MAIDEN NAME MAY COULTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY TUBERCULOSIS DUE TO (c) 11 months INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-13, 1956, to 8-21, 1957 , that I last saw the deceased alive on 8-21-1957 , and that death occurred at 12:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-26-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Wilson	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Newcomer		24. REG'D BY REGISTRAR 23 1957	
ADDRESS William Newcomer		24b. REGISTRAR'S SIGNATURE William Newcomer	

23 AUG 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08351

08349

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>White Marsh R.D.,</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Marsh R.D.,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1 Lorley</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Julius</u>		(Middle) <u>W</u>		(Last) <u>Venzke</u>		(Month) <u>Aug</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Apr. 15, 1897</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Venzke</u>				14. MOTHER'S MAIDEN NAME <u>Louise Cage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-0894</u>		17. INFORMANT & ADDRESS <u>Herman Venzke, Bradshaw, Maryland.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				10 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Hemorrhage July 1955</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Aug 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 24</u> , 19 <u>57</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Red O'Hodous</u>				ADDRESS (Street, city, town, state) <u>Edgewood Md</u>			
DATE SIGNED <u>Aug 24 1957</u>				DATE SIGNED <u>8-24-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEROF <u>Aug 27, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		LOCATION (City, town, or county) <u>Joppa, Harford, Md</u>	
24. REC'D BY REGISTRAR <u>AUG 29 1957</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Kennedy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCann Jr</u>		ADDRESS <u>Abingdon, Md</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NEW YORK

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

21. SIGNATURE OF CITY

22. SIGNATURE OF TOWN

23. SIGNATURE OF VILLAGE

24. SIGNATURE OF POST OFFICE

25. SIGNATURE OF SCHOOL

26. SIGNATURE OF CHURCH

27. SIGNATURE OF SYNAGOGUE

28. SIGNATURE OF MOSQUE

29. SIGNATURE OF TEMPLE

30. SIGNATURE OF OTHER

BUREAU V. 2

AUG 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08350

CERTIFICATE OF DEATH

08353

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave.				e. STREET ADDRESS 1910 Wilhelm Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Naomi Wagner				4. DATE OF DEATH Month Day Year Aug. 7, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1900	
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years last birthday) 57 yrs.	
11. BIRTHPLACE (State or foreign country) Balto. Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME late Wm. Thompson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (SON) Charles Wagner, 1739 White Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vasc. Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 dr. 5 yrs. (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-12 , 19 57 , to 8-7 , 19 57 , that I last saw the deceased alive on 8-6 , 19 57 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilmer K. Gallagher				ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Rd. 8-9-57			
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher				Catonsville 2E, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 10/57		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke, Funeral Directors, 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR AUG 14 '57		24b. REGISTRAR'S SIGNATURE Overh...	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1912		1957		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Time of Death		Place of Burial		Funeral Home		Burial Date		Burial Place		Burial Name	
Teacher		High School		Married		Hypertension		1956		10:00 AM		Catholic Cemetery		St. John's		1957		St. John's		John Doe	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Report		Time of Report		Place of Report		Signature of Reporter	
1957		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		1957		10:00 AM		Baltimore		[Signature]	

BUREAU V. 2

AUG 15 1957

RECEIVED

08354

CERTIFICATE OF DEATH

Reg. Dist. No.

08351

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sr. Mary Villanova Wankmueller				4. DATE OF DEATH Month August Day 8 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Newark, N.J.	
13. FATHER'S NAME Joseph				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Katherine Koelock							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier Address Notch Cliff Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis of the lung 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of breast DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. , 1952, to July , 1957, that I last saw the deceased alive on July 30 , 1957, and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell				ADDRESS (Street, city or town, state) 7501 York Road Towson, 4. Md.			
DATE SIGNED 8. 8. 57							
PHYSICIAN'S NAME (Type) Charles F. O'Donnell							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		8-10-57		VILLA MARIA CEM		NOTCH CLIFF NR TOWSON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell		ADDRESS 901 S. CONKLING ST. BALTIMORE, MD.		24a. REC'D BY REGISTRAR DATE 8/9/57		24b. REGISTRAR'S SIGNATURE Matel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	

BUREAU V. S.

AUG 12 1957

RECEIVED

8-10-57
J. J. GILKINSON
BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08352

08355

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD, MD.</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VETERANS ADMINISTRATION HOSPITAL</u>				d. STREET ADDRESS <u>1602 Johnson Street</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M.</u> Last <u>WEIR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Personnel Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Weir</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hesp., Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL WITH ABSCESS FORMATION</u> <u>491X</u> <u>EMPHYSEMA, LEFT LOWER LOBE AND POCKETED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>EMPHYSEMA, LEFT LOWER PLEURAL CAVITY</u> (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL EDEMA AND CONGESTION - Duration unknown</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-1-57</u>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>9/1/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>9/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. Farber</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. R.

SEP 5 1957

RECEIVED

08353

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 3307 KENYON AVENUE									
3. NAME OF DECEASED (Type or print) HARRY		First -		Middle -		Last WEITZEL		4. DATE OF DEATH Month AUGUST		Day 27	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1892		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard - Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government Post Office		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Frank Weitzel		14. MOTHER'S MAIDEN NAME Louise Keidel									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MASSIVE ASCITES DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 23, 1957 , to August 27, 1957 . XXXXXX and that death occurred at Lt. 45A , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Chien Wei Lan</i>	DATE SIGNED 8/27/57
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.	M.D. VA HOSPITAL, FORT HOWARD, MARYLAND VAH, FT. HOWARD, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/30/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 3331 Brehms Lane, Balto. 13		24a. REC'D BY REGISTRAR 8/29/57	
23. FUNERAL DIRECTOR'S ADDRESS Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farberg</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

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BUREAU V. S.

1957 39 516

RECEIVED

08354

CERTIFICATE OF DEATH

08357 43

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 428 Buck's School House Rd.		d. STREET ADDRESS Box 428 Buck's School House Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle F. Last White		4. DATE OF DEATH Month August Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Mary E. Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie L. White		Address Box 428 Buck's School House Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction DUE TO Atherosclerosis-Generalized Adu Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) under (c)			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Disease - many yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 13 to 25 Aug , 19 57 , that I last saw the deceased alive on 4:30 p.m. 25 AUG 57 and that death occurred at 5:39 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2527 Belair Rd. Balto. Md. DATE SIGNED 8-27-57			
ACTUAL SIGNATURE John C. Hyle		M.D. 2527 Belair Rd. Balto. Md.	
PHYSICIAN'S NAME (Type) JOHN C. Hyle			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 29, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Lutheran	22d. LOCATION (City, town, or county) (State) Belair Rd. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR AUG 29 1957		24b. REGISTRAR'S SIGNATURE Mrs. L. L. Ruffenberger	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HALE		AUG 29 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
DATE OF BIRTH		PLACE OF BIRTH	
AUG 29 1892		BALTIMORE, MD	
FATHER'S NAME		MOTHER'S NAME	
JAMES H. HALE		JANE H. HALE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
Carpenter		Homemaker	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
AUG 29 1892		AUG 29 1892	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
Natural		Natural	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
AUG 29 1892		AUG 29 1892	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
Natural		Natural	

RECEIVED
AUG 29 1957
BUREAU V. 1

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, ON AUGUST 29, 1957.

08355

CERTIFICATE OF DEATH

08358

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fullerton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>39 Sipple Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Lee</u> Last <u>Willinger</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>75</u> Days <u>13</u> Hours <u>19</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Greenwood</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Ruth Ryan 39 Sipple Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>Aug 13, 1957</u> that I last saw the deceased alive on <u>Aug 1, 1957</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D.				ADDRESS (Street, city or town, state) <u>6077 Haford Rd. Balto., Md.</u>			
NAME (Type) <u>R Donald Jandorf</u>				DATE SIGNED <u>8-14-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sarahm Funeral Home</u>				24a. REC'D BY REGISTRAR <u>AUG 15 1957</u>			
ADDRESS <u>7401 Belair Rd.</u>				24b. REGISTRAR'S SIGNATURE <u>W. L. Rafanides</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

AUG 15 1957

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Handwritten notes and signatures at the bottom of the page, including a date "Aug 15 1957" and a signature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08359

08356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sparrows Pt.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 C St.		d. STREET ADDRESS 810 C St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle I. Last Wittich		4. DATE OF DEATH Month Aug. Day 4 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 8 Days 15 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -----Hand		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Wittich, 810 C St. Sparrows Pt. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremic acidosis DUE TO (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hours 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25, 1957 to Aug. 4, 1957 that I last saw the deceased alive on Aug. 4, 1957 and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D Street Balto. 19, Md. DATE SIGNED 8/4/57			
ACTUAL SIGNATURE David Owens M.D.		DATE SIGNED 8/4/57	
PHYSICIAN'S NAME (Type) David Owens		DATE SIGNED 8/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7/57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave		24a. REC'D BY REGISTRAR Aug 7 1957	
24b. REGISTRAR'S SIGNATURE Dawson			

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 1, 1933		MOBILE, ALABAMA		UNITED STATES OF AMERICA	
MARRIAGE		EDUCATION		OCCUPATION	
None		High School		None	
RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
None		FIRE		Suicide	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
None		None		None	
TESTAMENTS		TESTAMENTS		TESTAMENTS	
None		None		None	

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JUN 12 1968
BUREAU X. 3